HEALTH CARE REFORM, RURAL SMALL BUSINESSES, AND THE RURAL HEALTH DELIVERY SYSTEM DEVELOPMENT ACT OF 1994

HEARING

BEFORE THE

SUBCOMMITTEE ON THE DEVELOPMENT OF RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

WASHINGTON, DC, JUNE 23, 1994

Printed for the use of the Committee on Small Business

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HEALTH CARE REFORM, RURAL SMALL BUSINESSES, AND THE RURAL HEALTH DELIVERY SYSTEM DEVELOPMENT ACT OF 1994

THURSDAY, JUNE 23, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE DEVELOPMENT OF RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:13 p.m., in room 2359–A, Rayburn House Office Building, Hon. Glenn Poshard (chairman of the subcommittee) presiding.

Chairman POSHARD. I think we will ask the Subcommittee on Rural Enterprises, Exports, and the Environment of the Small Business Committee to come to order. I want to thank you for attending this hearing. Our topic for the hearing is health care reform, rural small businesses, and the Rural Health Delivery System Development Act of 1994.

Various congressional committee hearings have focused in recent months either on the small business or the rural aspects of health care policy. Other hearings have examined the broader economic implications of health care reform; for example, employment effects or competitiveness. At this moment as we are in the midst of what is obviously a critical stage in health care's legislative process, I think it is important to take a last look at those topics together before final decisions are made concerning a health care bill.

What I hope we can help determine today is to what degree rural small businesses, the rural health care delivery infrastructure, and the rural economy in general requires special or additional consideration in health care reform. The bipartisan Rural Health Care Coalition here in the House, of which I am a member, has looked long and hard at this topic.

Our first panel will discuss the Coalition's main work product, H.R. 4555 the Rural Health Delivery System Development Act. The bill's two chief sponsors will explain its provisions, and we will ask today's other witnesses for their comments as well.

As an original cosponsor of H.R. 4555, I share my colleagues' hope that its provisions can make their way in whatever health care bill ultimately moves to the floor this year. As a bill or as a set of amendments, these provisions are a sort of yardstick by which to measure whether health care reform adequately addresses rural concerns.

The hearing also will consider the implications of health care reform for the rural economy. The problem of rural health care delivery has received much deserved attention, but we also need to know, as best we can, what the likely economic effect of reform will be, both the positive and the potentially negative.

The two major elements of reform, universal coverage however we define or whenever we reach it, and cost containment however that is achieved, will have economic consequences in rural communities. The mechanisms we choose to pursue universal coverage and cost containment should be examined with particular attention to how they will affect the rural economy. Of course, failure to pass meaningful health care reform would also have serious economic effects, and knowledge of that fact is a part of our equation as well.

Our second panel consists of local experts. Mr. Harvey Pettry is the administrator of Richland Memorial Hospital in Olney, Illinois, which is in my home district. Dr. Rolf Habersang is a pediatrician in Amarillo, Texas, which is in the home district of Congressman Sarpalius. These two gentlemen will discuss, among other things, the connection between what they do — they are practitioners in the health care delivery sector — and the local rural economy where they live and work.

Finally, I am pleased that we have with us Jeffrey Human, director of the Office of Rural Health Policy at HHS. Mr. Human is accompanied by Bob Van Hook. They will present the administration's views concerning rural health care reform including how reform might affect the rural economy. I hope we can also get them to comment on the rural reform provisions suggested by H.R. 4555.

In addition, we have Charles Fluharty, who is director of the Rural Policy Research Institute. RUPRI has been conducting important economic analysis concerning health care reform and the rural economy, and I look forward to what I am told will be a preliminary description of their findings here today.

So, I want to welcome all of you to the committee hearing, and I would ask Mr. Hefley at this point in time for his opening statement for the hearing.

[Chairman Poshard's statement may be found in the appendix.]

Mr. HEFLEY. Thank you, Mr. Chairman, and first of all I would like to welcome you to your new position of prominence as our leader of this committee, and I think we are going to have a good time, and I think it is very appropriate that this would be the first hearing that we would talk about rural health care.

Rural health care is a big concern in the district I represent and the districts that most of us represent. This area of health delivery has always faced unique hurdles in assessing their health care and their concerns need to be represented, I think, in any health care reform debate. Congressmen Stenholm and Roberts have led the way in this effort. Their Rural Health Care Caucus has been working to improve health care access in rural areas long before health care reform became the fashionable topic of the day. Their bill, H.R. 4555, represents years of hard work, and while I have some concerns over the legislation, I look forward to hearing their testimony.

I also look forward to hearing the testimony of the other groups and individuals who are directly involved in providing sparsely

populated areas with health care. It is an important topic, it is a timely topic, it is vital to rural small businesses, and I appreciate the chairman choosing this as our first hearing under his leadership.

Chairman POSHARD. Thank you, Mr. Hefley, and I certainly look forward to working with you on this committee.

I would ask if any other members of the committee have opening statements at this time.

Mr. Sarpalius.

Mr. SARPALIUS. Thank you, Mr. Chairman. I, too, congratulate you as the new chairman of this committee and look forward to working with you.

In rural America, health care is a very serious problem, and I too commend Congressman Stenholm and Congressman Roberts for their leadership in dealing with this issue.

There are 7.7 million rural people who lack health insurance; 26.5 percent of the rural uninsured people in this country are children. The rural nonelderly residing in the south are more likely to be uninsured than their counterparts in other areas of country. Rural workers are less likely to be insured than their urban counterparts. Forty-two percent of the rural uninsured are working. Nearly 60 percent of the nonelderly rural uninsured who are working are employed by firms be with fewer than 25 employees.

In Texas, my State, there are 23 rural counties without a single primary care physician. Seven of these 23 counties are in my congressional district. Believe me, I have heard from many of my constituents who do not have adequate access to a doctor. Many of these individuals do not have a hospital alternative for care either. There are 56 Texas rural counties without a hospital, 12 of which are located in my district.

So, I think it is vitally important that as we begin to focus on health care for this country, we do not forget those people who live in rural areas who are not fortunate enough to have health care readily available to them. It is important that those American citizens who live in rural America have available to them the same quality of health care as those that are located in urban areas.

Mr. Chairman, I appreciate your leadership here, and I am also very honored to have with me today one of my constituents, Dr. Rolf Habersang who serves on my health care advisory committee that I have put together in my congressional district. We will hear from Dr. Habersang on the second panel.

[Mr. Sarpalius's statement may be found in the appendix.]

Chairman POSHARD. Thank you, Mr. Sarpalius.

Mr. Manzullo.

Mr. MANZULLO. Thank you, Mr. Chairman.

The whole issue of the delivery of health services to rural areas of course is unique, so unique that I am going to be traveling down to Mr. Poshard's district. I live at the top of Illinois, almost near the Wisconsin border, and my staff realized that it is closer from Rockford, Illinois, to Cleveland than it is from Rockford, Illinois, to where Mr. Poshard's district is, so we are going to have a new taste of rural America when we bring our crew down there.

But it is important because the hearings that Mr. Poshard will be conducting are in the areas of rural health care, a very unique situation in a very unique State.

So, Glenn, I commend you for calling these hearings, and I think this is an appropriate forum before we proceed to your district on July 8.

[Mr. Manzullo's statement may be found in the appendix.]

Chairman POSHARD. Thank you.

All of us on this committee have worked for a number of years now with the gentleman on our first panel. Charles Stenholm has been a leader of the Rural Health Care Coalition of which there are 150 or so Members in this House, and he has put together a bill this year with Pat Roberts who also has been a cochairman of that coalition with Congressman Stenholm, a bill that I think speaks to the peculiar problems that we have in the rural areas with respect to health care reform.

I want to welcome you to the hearing today, Congressman Stenholm, and we will begin with you and your testimony at this time. I am assuming that Pat will be along shortly.

TESTIMONY OF HON. CHARLES STENHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. STENHOLM. I'm sure he will.

Thank you, Mr. Chairman. I commend you and other members of your committee for scheduling this hearing on health care reform, rural small businesses, and the Rural Health Delivery System Development Act of 1994.

I know that you have long been an advocate for rural areas when it comes to health care delivery. For the past 4 years you have been a valued member of the Rural Health Care Coalition Steering Committee in our capacity as chairman of the Rural Mental Health Task Force, and, as you know, on behalf of my cochair, Pat Roberts, and other members of the House Rural Health Care Coalition, we have now introduced the Rural Health Delivery System Development Act of 1994, H.R. 4555.

Mr. Chairman, I would ask that my entire statement be made a part of the record, and I will summarize significant parts of it.

Chairman POSHARD. Without objection.

Mr. STENHOLM. Recognizing that we are just one piece in rural America of the larger health reform picture, we nonetheless have felt that during this period of reform it is absolutely critical that the concerns and needs of rural America be heard, respected, and responded to.

In constructing this bill, we in the Coalition sought to identify those consensus initiatives which did not presuppose any one approach to overall health reform. Within the Coalition we have members who support medical savings accounts alone, single payer advocates, those who support employer mandates and others who oppose them, managed competition believers and managed competition skeptics. What unites us, however, is our desire to promote rural health provisions regardless of the system reform.

Having served as a member and subcommittee chairman here of the Small Business Committee, I know that most of this committee's members have a sensitivity to the role rural health plays in

rural development and rural enterprises. We understand that if there are not health care providers in rural areas there also will not be businesses which can sustain a thriving community.

Here in the Small Business Committee we also know that rural communities are not looking for handouts, they are not asking for the Federal Government to solve their problems, they don't want the Federal Government to parachute in with magic answers. What rural Americans would appreciate is some help with the tools that they need to deal with their local problems. They want to be able to create the systems that meet their local needs. This is true whether we are talking about health care, business development, education, or any other aspect of rural life.

What health reform should ensure for rural communities is community-owned, integrated delivery systems that organize the rest of the system from the bottom up. That philosophy is precisely at the core of the bill we have introduced, building on the foundation of programs which we know have worked in the past and incorporating some new ideas of what we believe in the future. We are seeking not to prescribe the magic answer for the thousands of rural communities across our country but, rather, enabling them to coming up with their own answer.

In taking this approach, we not only enable individual rural communities to take responsibility for their own answers, we also give them the tools to go beyond the piecemeal approach of some past rural programs, equipping them to respond comprehensively to their rural health needs.

In the Rural Health Delivery System Development Act we give special attention to those chronically underserved rural areas which, in spite of existing Federal and State programs, continue to lack access to affordable high-quality health care services. Our goal is to catch those communities which previously have fallen through safety nets, encourage their own self-developed plans, and enable them to coordinate services to their residents.

The financing mechanism which we have included in this bill — and I will leave the description of several other Grant and tax proposals to Mr. Roberts, but I do want to address the financing of this bill. Basically what we suggest is applying an affluence test to Medicare Part B premiums. Those individuals making over $100,000 or couples with incomes of more than $125,000 would be asked to pay a greater share of their monthly premiums for Part B Medicare.

Although this provision would affect only 2 percent of the Medicare population, it would generate revenues of more than $4 billion over 5 years. According to the best estimates we have, the bill's financing fully covers the cost of the programs which we have outlined in H.R. 4555. Should later scoring show an unexpected shortfall, we will make adjustments in the bill as necessary.

With crystal ball gazing having still not developed into an exact science, the authors of this bill make no presuppositions about what form health reform will take in the 103rd Congress. We believe that H.R. 4555, however, will fit into any larger health reform picture.

Let me mention finally that I commend you for the witnesses you have gathered here for this hearing today. Dr. Habersang comes

from a district which neighbors mine. I know he has an excellent understanding of the difficulties and, more importantly, the successes that are possible in rural areas. I believe he will mention in particular two provisions, the Border Health Commission and the revising of the formula for reimbursing rural physicians which are a particular interest to Texas.

I am also particularly pleased to see my friend Jeff Human who has led the Office of Rural Health Policy since we first created it at the beginning of the Rural Health Care Coalition's efforts.

Finally, I want to mention that Chuck Fluharty, who will represent the Rural Policy Research Institute, provided extremely valuable input as we were developing H.R. 4555.

Again, Mr. Chairman, thank you for conducting this hearing. I look forward to working with all of my colleagues in seeing that these provisions are enacted into law.

[Mr. Stenholm's statement may be found in the appendix.]

Chairman POSHARD. Thank you, Congressman Stenholm.

We are going to go on with questions for you, and if Mr. Roberts shows up a little later we will get him included. But before we do that, I see Congresswoman Danner from Missouri is with us now and I wanted to see if she had an opening statement.

Ms. DANNER. No, I do not, Mr. Chairman. Thank you.

Chairman POSHARD. All right. Thank you.

Congressman Stenholm, you have spent so many hours on this issue of rural health care reform. Can you just briefly explain to us where you see the major concerns or the major differences between rural health care reform and what we may be encompassing in the urban area? What are the essential things that we need to be dealing with in the rural areas to make sure that our people get the same access to health care reform that people in the urban areas are trying to get in reform?

Mr. STENHOLM. Well, I think the first answer I would give you to that is calling attention in our bill that we are looking to bottom-up solutions.

When we talk about rural America we tend to talk generically, but all rural areas aren't equal. Some are further from health centers than others. Some have unique problems. Some have different ideas about how their community needs can best be served. So, one of the key points of our legislation is to recognize that we are not all cut out of the same block, that there are differences, and what we hope to do is encourage the intellect, the ideas, from the bottom and recognizing that perhaps some things ought to be tried before we legislate a final solution in the big picture.

So, many times we come up with ideas here in — and this is what is being debated in other committees right now — of which one size is supposed to fit all. We know in rural America that that is not true. I have had some great success stories coming from my district, from the one community health clinic that we have presently. I happen to believe we need more of them.

I think, in order to provide for access to health care to rural communities, that the concept of community health clinics makes good sense, but I hesitate to try to write the legislation that would fit each of our 50 States based on what may or may not work in the 17th District of Texas, and therefore we provide grants to those

communities and individuals and areas that can come up with plans that can be sold to those who are looking at it, for example, in the Office of Rural Health and others, saying this we believe will better present what the heart of your question was, access to health care.

If you lose your hospital in a rural community, you have got a major problem unless you have a constructive alternative. In my district I have lost 11 hospitals in the last 10 years; they have closed. I have got another 10 hanging by a thread.

I do not suggest that all of those who are closed should have stayed open, nor do I suggest that all of those 10 hanging by a thread today should remain open, but if they close and you do not have a plan, whether it be a community health clinic, whether it be access to a doctor, to a clinic, to some type of medical assistance, the community is dead.

Therefore, the uniqueness — and I guess the other point that I would want to make in answer to your question, I have noticed in our work in rural America that we have a lot of things in common with the urban inner cities. When we start talking about access to care, to the availability of doctors, general practitioners, nurses, et cetera, we have similar problems that need to be solved, and I am hoping that as we get into the debate on the floor we will find a coalition between our urban brothers and sisters and rural in order to see that we, in fact, get those kinds of tools made available to us.

Chairman POSHARD. Can you just explain for the committee, basically play out for us the scenario of how a State would access the planning moneys and the TAG grants for networks in the rural areas? How would that work? What is the Federal agency that would handle that? Would States apply? This is Title I of the bill wherein we are looking at networks and sharing resources and so on. What is the intent of Title I basically, and how would that work out?

Mr. STENHOLM. The intent is to provide assistance for development of these States' access grants. We would anticipate that governors may, in conjunction with local communities, develop and implement actions or plans to, in fact, motivate, develop, the care for the specific areas within their State.

As I mentioned, all areas are not alike, so we anticipate that governors, through the appropriate entities within their States, would develop the plans, make applications for the grant funds based on a plan that has started at the bottom up at the community level and then move upward through the State, then to the Federal level.

Chairman POSHARD. OK.

Mr. Hefley.

Mr. HEFLEY. Charlie, I'm particularly interested in the statement you made about one size doesn't fit all. That is one of the things that has concerned me the most, I think, in this whole health care debate that we have had, that we seem to be talking about, or at least the administration seems to be talking about, some kind of a health care reform plan that will be projected on to every community and every person in this country, and I have often wondered why, as an approach to health care reform, we don't turn the

States loose a little more, not hold them so tight, and let them experiment with various kinds of health care reform, and then maybe somewhere down the line we would take the best of these experiments, let them be a laboratories. Have you gotten much support for this concept that we shouldn't consider one size fitting all?

Mr. STENHOLM. Well, I guess the first thing, I think it would be very good for Texas, but I'm not sure Colorado could be trusted with that type of a program.

Mr. HEFLEY. Well, you are absolutely right there, no question about it.

Mr. STENHOLM. No, seriously, that is the whole idea and spirit which I think pervades the whole rural effort into this. Recognizing that it is impossible to draw up those plans, we hope — on the question Mr. Poshard asked a moment ago — we hope that we will challenge the individual States to come up with the plans. There will be a competition, because there is not enough money in our bill, nor could there be in any bill that will be paid for, that will allow every idea to be tried.

But by challenging the ingenuity of the individuals within the various States and communities who are already way ahead of us — a lot of what we are talking about here, most of it is already being tried in some shape, form, or fashion because it is the only way rural communities are surviving.

So, what we hope to do in this is to provide competition between States, competition between areas within the States, to come up with the ideas, to try them, and the better ideas we hope will be granted the grants, and where they work quickly we will copycat them in every other region of the country.

What works in your State, in some community, if it works, quite possibly will work for me in my community, and through this networking that we keep talking about that is happening through finally the recognition of rural communities, they are going to survive in only one way, and that is cooperatively, working together, coming up — borrowing ideas, sharing the ideas with each other, and the beautiful thing about this, it is already happening, but now what we want to make sure is that we take the resources, whatever are made available, and expend them in the most efficient way.

Mr. HEFLEY. Well, I'd just like to ask you to share this philosophy with the White House, and maybe they would extend that to the rest of the health care reform package as well, because if it works for rural areas maybe it would work for health care reform in general.

Mr. STENHOLM. I happen to believe very strongly that it would, and we are sharing it with anybody that will listen as often as we get a chance.

Mr. HEFLEY. Thank you, Mr. Chairman.

Chairman POSHARD. Thank you, Mr. Hefley.

Mr. Sarpalius.

Mr. SARPALIUS. Thank you.

Congressman Stenholm, 76 percent of the population below the poverty level resides in rural areas. Of that, almost 20 percent of poverty-stricken people are children. These children are much less likely to receive health care than their urban counterparts. Have

you considered including a school-based health care program in your bill? If not, what do you have in your bill to ensure that these children have good health care?

Mr. STENHOLM. I'm not sure of directly a bill that we have considered as a school-based plan. I would be curious to know specifically what you might be referring to.

What we have included in the bill though — and this is critical, and I guess it is along the line of the first part of your question, and that is recognizing that preventative health is the best dollars that we can spend, and preventative health for children is the soundest dollar that can be spent in health preventative care, period.

You know, that is where — as we testified in the Agriculture Committee, where we pointed out that agriculture and health care have something in common, and that is good nutrition. If a child does not get a healthy start from the womb through the first 3 or 4 years of its life, it is going to be a drag on the educational system, it is going to be a drag on the business system, and that child is going to end up being a crime problem; they are directly attributed to each other.

So, what we hope in this is that the emphasis on community health clinics and, by their very nature — and again, in the experience of the one in my district, where you have a community health clinic you have better utilization of the immunization programs, you have better utilization of prenatal health care, which is some of the best health care you can get for children. If the availability of those service is not there, you are going to have a problem. Therefore, we suggest provide access to it strategically placed.

I guess if I could suddenly get a magic want to do certain things, first I would like to see strategically placed community health clinics, whatever you call them. Here again, States are different. Different States do them differently. Some are doing them privately. It matters not to me, but to make sure that we have them there so that access, in this case for children's programs, will be there so that they are there, and then allow the local communities to make certain that they are utilized as best you can.

Mr. SARPALIUS. Let me share a concern. Many times we have a tendency to set formulas on funding based on the percentage of unemployment in an area. We assume that if the poverty rate is high unemployment is also high. When funding is based on a formula like this, rural areas lose because our unemployment is not high. When people lose their jobs in rural areas they leave, so unemployment numbers do not look high for rural areas. Yet the poverty level among rural areas is very high. I suggest that we look very closely at any health care bill that uses such formulas. When we base funding on unemployment figures, rural areas lose.

Let me ask another question. In your bill you provide incentives encouraging doctors to come into rural areas. Most of these incentives are aimed at young people who are studying to be doctors. But do you have any incentives for doctors that are currently practicing in more priveliged, more urban areas to go practice 2 or 3 days in a rural area? Is anything like that in the bill?

Mr. STENHOLM. It has been suggested that we ought to have some tax incentives to provide the economic incentive to currently

practicing physicians and others in the delivery of the health care system to relocate utilizing the Tax Code. I think it is a good idea.

You mentioned the concept of providing financial incentives. You know, the way we envision this, if it is going to work, you have to get local input, and that is why we emphasize in most cases rural communities are not looking for a hand-out, and the spirit in which we think this incentive for education, for providing an increase in the supply of so-called general practitioners, would work best if local communities that have a need for additional physicians would provide scholarships to deserving young men and women within their own community. Those communities that do should be eligible for State grants because in most cases we hope that individual States — Texas certainly is moving in this direction — would provide matching funds, and perhaps we could take the funds that we have in this bill and then match the matching funds.

The key is that the local community provides the first impetus to getting someone from that community trained with the understanding that that individual will come back and practice for a given period of time. Then, after that point, if more rural communities are participating in this program, we will increase the supply, which is what we are after, and we will have trained a large number of young men and women who, for the most part, would like to come back to rural America if they had the economic incentive, if they had the other parts, and we hope a small part will be answered in the bill before us.

Mr. SARPALIUS. Let me mention one other thing quickly. I know we have a vote. You and I both serve on the Ag Committee. At the end of World War II, the Government set up incentives for many veterans to buy a farm, so now there are a lot of veterans living in rural America who have to travel long distances to reach veterans hospitals or other places that provide assistance.

We set up a program in my area so that veterans can go to a local rural hospital to receive treatment. Besides shortening the distance these veterans must travel, this program provides additional dollars that go into rural hospitals to help them continue to exist.

You have also been an active member of the Veterans Committee, and I would strongly urge you to look at this veterans program because I know in our case it has been extremely successful.

Mr. STENHOLM. I could not agree more. If you talk about a political hot button though, you have touched one there. But I would hope that the veterans community would sit back and take a good hard look at what the veterans health delivery system is all about, and that is to deliver health care to those who have served this country. It is not there to maintain an institution, it is there to deliver health care, and in rural areas I think that there can be some wonderful improvements for the general community and the increased availability and quality of health care by looking cooperatively, and that is why in our bill the provision for networking, at least in this Member's mind, we are talking just about the concept you bring up of suggesting to rural communities how do we best serve the total needs of all of the people within that rural area, and in that instance, perhaps through a cooperative effort, working with the veterans community and the small business community,

the agriculture community, and those who are very interested in the delivery of health care which you will hear in the next two panels, that we can come up with ideas that will deliver that health care more efficiently. I want to say "cheaper," but "more efficiently" sounds better.

Chairman POSHARD. OK. Thank you, Mr. Sarpalius.

We do have a vote on, but we have got a few minutes left, and I want to ask Mr. Manzullo to finish his line of questioning.

Mr. MANZULLO. I just have a couple of questions.

Chairman POSHARD. OK.

Mr. MANZULLO. Charlie, how far do some people have to travel to get to a physician in your district? Do you have any idea?

Mr. STENHOLM. Probably, the furthest point would be 60 miles, maybe as much as 100.

Mr. MANZULLO. It would be the same generally for going to the nearest hospital?

Mr. STENHOLM. Yes, it would be about the same.

Mr. MANZULLO. Thank you.

Chairman POSHARD. OK. Thank you Mr. Manzullo.

We are going to take a 15-minute break here. Mr. Stenholm will not be able to be back with us after the break, so we will go straight to the second panel hopefully by 3 o'clock.

[Recess.]

Chairman POSHARD. Folks, I think the subcommittee will reconvene.

We are going to have votes all afternoon, I would suspect, and so rather than wait for all the individual members of the committee to return each time, I think we will just proceed because we don't want to inordinately delay the committee hearing. There are folks here who have planes to catch back to their homes and so on. So, we will just continue.

I want to introduce to the committee at this point in time Mr. Harvey Pettry, administrator of the Richland Memorial Hospital in Olney, Illinois, in my district — welcome, Harvey, to the hearing — and Dr. Rolf Habersang, a pediatrician from Amarillo, Texas.

Welcome, gentlemen, to the hearing, and we will begin with Mr. Pettry.

TESTIMONY OF HARVEY PETTRY, ADMINISTRATOR, RICHLAND MEMORIAL HOSPITAL, OLNEY, ILLINOIS

Mr. PETTRY. Thank you, Mr. Chairman.

My name, as you said, is Harvey Pettry, and I have served as administrator of Richland Memorial Hospital for 10 years. I am a member and treasurer of the Illinois Hospital Association board of trustees. Our hospital is located in Olney, Illinois, a rural community of 9,000 people in the southeastern part of the State.

Richland Memorial is owned by the Richland County Board and our governing board is an elected county board. We run a daily hospital census of approximately 65 patients. We provide services to the residents of Richland County and the surrounding seven counties. About half of our patients come from Richland County, and the other half come from the surrounding counties in varying percentages. We employ 450 full and part-time people.

As a hospital in a rural community, we provide typical inpatient services plus psychiatric and long-term care beds. We also provide typical ancillary services but with an increasing emphasis on rehabilitation services. We provide some nontraditional services in the form of the county ambulance service. We have a home health program that is working in five counties. We have a hospice program working in four counties.

I would like to call your attention to our role as an economic force in our community. As I have said, we employ about 450 people. This is 5 percent of the local work force, and we have an annual payroll of $7.8 million. We also spend an additional $2.2 million locally for goods and services.

Most of our medical staff members are members of the 21-member multispecialty group practice, the Weber Medical Clinic, that was organized in 1896. The Weber Medical Clinic employs 100 full and part-time employees and has an annual payroll of $5 million.

Therefore, in our small community health care contributes almost $13 million in payroll plus about $2.5 million for other expenditures in the community.

I would like to call your attention to our contributions to the growth and development of our community beyond our role as health providers and employers. We are directly involved in the training and education of a large number and variety of allied health personnel, and this greatly increases the availability of health manpower for many other providers in our area.

Our community involvement also includes our employees serving on school boards, on economic development groups, health-related groups such as the Red Cross, Salvation Army, and so forth.

We are also the sponsor of a variety of community and patient education programs, patients with cancer, diabetes, for the families of Alzheimer's patients. We are also assisting two adjoining counties in upgrading their ambulance services from EMT-A to the EMT-I level.

These noncompensated contributions and services that I just referred to are not freebies that we have given away in competition with other neighboring hospitals, they are community commitments on the part of our hospital and our employees. They affect the quality of life in our

community.

I would like to make a few comments about the Rural Health Delivery System Development Act of the 1994. I have had an opportunity to read an outline of the legislation. I am truly excited by it, and I strongly support it.

I think the section on encouragement to States in development of State access plans is very important and necessary if it is to move forward. I think the technical assistance for grants and assistance for development of networks is extremely important. Without the assistance, rural hospitals will have great difficulty in developing their roles in networks.

I am excited about the continued development of incentives for health professionals, but I hope that there will be incentives for recruitment and for retention of personnel.

The provisions for innovative institutional programs, especially those relating to emergency medical services and telecommuni-

cations, are very important. The distances between hospitals is going to become greater as some small hospital facilities change to other purposes, and these institutional programs will be important linkages between those facilities.

I hope you will have an opportunity to read my further comments on the act and my printed statement.

If I could, I would like to just make a couple of comments on health reform. The first relates to universal coverage. Five to 6 percent of the people in our area have no health insurance. These people are too rich to be on Medicaid yet too poor to have any insurance. Most of them are small business people, farmers, and so forth, and a lot of them suffer from unnecessary illness and premature death.

How can we accomplish health reform without covering them? If we don't cover these people, then the individuals to benefit from health reform will be individuals such as myself, and I already have good insurance. I hope that reform will include Medicare as an integral part of the reform program.

It is difficult for me to imagine how we could have health reform if we don't include Medicare, which is 55 percent of our patient load. If we don't involve Medicare parents, then we will have 55 percent of our patients covered under the old Medicare Program and we will have 45 percent of our parents covered under a new health reform program. This will result in two different sets of incentives for our doctors and for our employees to respond to, and I think that will be an unworkable situation.

One further comment. I would like to express my deep concern about Medicare spending cuts. I understand that there is strong support for cutting Medicare as a way of paying for health reform. I believe that the proposed cuts will prevent hospitals from taking care of their Medicare patients and their other patients and this will ultimately negate the anticipated benefits that we all hope for from reform.

I very much appreciate the opportunity to appear before you this afternoon. I think that the Rural Health Delivery System Development Act of 1994 has great promise for the residents of rural areas. Furthermore, I believe that as congressmen representing rural areas you can impact on health reform and you can make it beneficial for our rural areas.

I hope that your subcommittee will pursue these important legislative initiatives in order to continue the viability of health services in rural area and with the additional benefit of maintaining the important contributions that rural hospitals make to their communities.

[Mr. Pettry's statement may be found in the appendix.]

Chairman POSHARD. Thank you, Mr. Pettry.

We will go to Dr. Habersang now.

TESTIMONY OF ROLF HABERSANG, PEDIATRICIAN, AMARILLO, TEXAS

Dr. HABERSANG. Thank you.

Mr. Chairman, my name is Rolf Habersang. I am a pediatrician caring mostly for children with special health care needs in Amarillo, Texas. The community itself has 165,000 people, has a medi-

cal center which covers about 450,000 people, and I have patients coming to my practice as far as 115 miles just for an office visit. We are also serve neighboring Oklahoma, Kansas, and New Mexico.

I have been 21 years in practice, the first 4 as a teaching professor in Kansas City, Kansas, and then 14 years at the Texas Tech University School of Medicine in Amarillo. I have been in private practice now for 3 years basically taking care of children with special health care needs. I am in a group practice which we started and there are two pediatricians right now and three advanced nurse practitioners.

Though most of my work is concentrated in Amarillo, my group has worked and is working with the Public Health Department as there are only four pediatricians outside of Amarillo in the whole panhandle area, and so we all have basically voluntarily assigned one town, about 50 to 100 miles away, where we go at least once a month to see consultations.

Chairman POSHARD. Doctor, would you excuse me. Would you pull that microphone a little closer so that the audience can hear you.

Dr. HABERSANG. Yes.

Chairman POSHARD. Thank you.

Dr. HABERSANG. The point I want to discuss is the impact of health care reform on rural health care delivery and on rural small business, as every physician practice out there is a small business, usually a small one, relatively speaking.

I reviewed the concerns with regard to health care reform with a fair number of colleagues of mine who refer patients to me, and their concerns are mostly three. First and actually most important, the shifting of health care services, even basic primary care, from their rural site to the next city 50 or 100 miles away; number two, the manpower shortage and professional isolation which kind of go together; and, last but not least, reimbursement.

With the shifting of health care services with the trend to managed care and the development of larger groups, the need for primary care physicians as gatekeepers in big cities increases. Because of the shortage of primary care physicians in general, primary care physicians are also recruited from rural America right this moment because they can get better money and much less hard work, and when you are 40, 50, or 60 and have done it for 20 years, that is a great incentive. So, things actually with health care reform may get worse out there with regard to access because physicians are leaving right now.

Manpower shortage and professional isolation. Several of my colleagues out in the rural communities have major concerns, and I have talked to one pediatrician who, actually, I was involved in training, who spends 27 nights a month being on call because she is the only pediatrician in that town, and actually between her and Amarillo there is nobody. When she goes out of town, which she only does Wednesday afternoons unless there are family emergencies, she has somebody covering who does not feel very comfortable taking care of children below 2 or 3 years of age.

In addition to the frequent night and weekend calls, professional isolation is a problem because when you are living with other pedi-

atricians, if you have a problem, you can just go across the hall or you meet them at lunch somewhere and you can talk and discuss patient problems. When you are out there by yourself, the only thing you have got is long-distance telephone, which is good but at times very difficult.

What then possibly can prevent patients from being transferred to larger communities, which is right now happening at an increasing rate? If rural physicians do not only function as primary care doctors and we also talk about primary care, what I am suggesting is that a physician out in rural communities needs to be more than just a primary physician.

I don't want to take anything away from a primary physician, but chronic illness, which is kind of fitting into a secondary level of care, needs to be taken care of at home, which means these physicians actually need to be better trained than their big urban counterparts who can consult anybody in 5 minutes.

For this to happen, primary physicians must be better trained and they must have continued education with colleagues whom they can talk to, which means we cannot just send one person out there.

As Congressman Sarpalius stated, in our part of the country in the Panhandle of Texas, out of 26 counties there are 11 who have either no physician, period, and five who have one. Those folks are not going to stay there very long, because how long can you be on call and be responsible for everybody in town and the surrounding area without breaking basically yourself? The way I read the bill is with nurse practitioners and physician's assistants.

I calculated before I went into practice that to use my time efficiently, you should have a ratio of about 1 to 2 or 1 to 3, and right now I have 1 to 2.6. As we get more pediatricians, we will have more practitioners because especially children with special health care needs need a lot of work which I am not necessary for, but nobody else does it, so we do it through the office.

A word about reimbursement. In Texas we have also Medicaid. Right now in Texas, 50-plus percent of babies born are born to mothers who are on Medicaid. The problem is that the reimbursement is such that in many areas, towns, cities, and rural areas, physicians do not take that credit card. To say it in my words, it is the gold card nobody wants. When I look at health care reform, I don't want a platinum card which nobody wants because that will actually on paper result in benefit and in reality will make things much worse.

Now I want to say a few words to the economic impact of any health care reform. In the Journal of the Oklahoma Medical Association in 1988, the dollars — you have got to figure out what the dollars will be nowadays — there was a study done which estimated that a single physician practice in a rural community generates directly and indirectly 17.8 jobs and a payroll of 343,000 plus. That is 1988. So, I'm quite sure that is more.

The availability of adequate health care services is closely related to economic viability. We heard before hospitals closing, physicians are leaving, and as a result a major economic stimulus is gone.

Business, new business, cannot and will not locate in places where the business owners and the employees cannot get health care, it is illogical, and so the only way we need to work is to be sure that any health care reform bill will address the fact that we need to have more help for keeping rural health care services in a good state or get them in a good state of health so that we don't really basically lose rural America, and, tongue in cheek but not quite, I want to say if everybody leaves out there, who is going to grow the wheat and the beef? Sooner or later we all would like to eat something.

With the health care reform, everything being in grand scale, we are used to talk about the economics of scale being very beneficial. In rural health care, that will be a killer because you cannot have 50 physicians out there because they can't live, they will have to farm in addition and do something else, so you will have a small group, and you will have different practice conditions.

Health care out there is very different. I learned it when I came to Kansas, I learned it when I came to West Texas, and I am not sure when I read the bills, except the one we are discussing today, that this is really recognized in a fashion more than just, we will think about it, and so I am very concerned that the health care reform, with all its good ideas — and being a pediatrician, I have got to put a plug in while adults are suffering, children are suffering much worse, and in rural America they suffer even one more degree worse, so please don't forget them either. But we need to look at any bill to include not disincentives for delivering health care out in rural America.

Thank you.

[Dr. Habersang's statement may be found in the appendix.]

Chairman POSHARD. Thank you, Doctor.

Let me refer to a point that both of you made, and being somewhat familiar with Richland Memorial Hospital and Mr. Pettry's operation there, I want to tie this into the local economy, if I can, and with the problem that our Federal Government has, the greatest problem we have which, in my estimation, is the $4.3 trillion of indebtedness and our inability somehow to begin to turn the corner on that.

When I look at rural health care across my district, I see some hospitals that are success stories such as Richland Memorial right in the middle of an agricultural area. I can go not too much farther away from that and see 35 and 40-bed hospitals that have an average patient load of three or four people a day. They are maintaining a physical facility, they are maintaining specialists, technology, et cetera, and being heavily subsidized by the Federal Government through Medicare, Medicaid, and so on.

Now if we are going to squeeze — I don't want to call it abuse — out of the system, but if we are going to squeeze the inefficiency out of the system, how are we going to do that while at the same time taking into account your concerns that we don't start looking at everything on an economy of scale basis, at the same time cognizant of our responsibility out here of getting this deficit under control and beginning to bring this debt down?

How do we do that unless we look at the rural areas and say at some point in time you have to come to grips with this problem of inefficiency in the system?

Now what do we do? How do we get the folks in the rural areas to understand that we have to begin to network, as this bill talks about, we have to begin to share resources, share technology, share specialties, do what is necessary to develop a cost-efficient system? Because there is a lot of waste in our system, frankly, and that waste is maintained today, in my judgment, through a lot of artificial boundaries such as county lines, county boards, political considerations that absolutely drive me crazy when I try to deal with it. How do we do it?

What, in your judgment, do we need to do? Does this particular piece of legislation, does the President's bill, does anybody's bill out here speak to a way to break down those artificial boundaries that divide us in the rural areas and create this kind of inefficiency? I am just wondering what your thoughts are on that.

Mr. PETTRY. I don't think the President's bill really speaks to that.

In a lot of ways the political boundaries — and it is almost like home town football teams on Friday night: "I've got my hospital and you've got yours; I want to keep it that way." I think you have to go beyond that argument and recognize that those facilities were built in a different age for the different health care system, and we have got to go beyond that and say: But with the changes that are coming, you are going to have a facility, but it is a different facility. You are going to have a facility that provides a different level of services in your town of 5,000 people than what you have historically been used to, but it will still be high-quality services for pediatrics, pregnant women, and so forth. It won't do everything in your community that it used to do.

I think you have to go beyond that also in terms of types of personnel that are available. I think you have to change the incentives that are there. But I also question how much will we truly save when we take a hospital that is 50 years old and probably close to fully depreciated and we quit turning the lights on every morning. I'm not sure that we will save a lot of money. The money will come through the change in treatment patterns, the prevention, the issues on living wills, those kinds of things, and what sorts of services, what sorts of practices what sorts of treatment methods are most effective. I think that will save money in the system. I am not sure turning off the lights in a fully depreciated building will save us a great deal.

Chairman POSHARD. So from a Federal perspective, we ought to be offering the inducements or the incentives or the ear of corn, so to speak, to make those role changes possible in the way medical care is delivered without looking at putting this community hospital out of business just because it is not making money right now.

Mr. PETTRY. That is correct, sir, and I think if you could get a community to focus on that 1953 hospital as now the site of their ambulance service, their emergency room, their outpatient lab and x-ray services, their home health program, their health department, because that is the focus of the health needs of their community now, and if you have to have visiting specialists, that is very

helpful, but you have got to get them to refocus on bricks and mortar for that different purpose, and it is still important to them.

Chairman POSHARD. Doctor, let me ask you a quick question. When I was in the Illinois State Senate, we were allowed to give, I think, eight scholarships a year to aspiring students, and those were State scholarships, and I always reserved half of those for students in medical school in my district, which was a rural district. I went back when I began my tenure here in Congress and looked at the number of scholarships that I had given over the years as a member of the State Senate and at how many of those young people settled in the rural area that I represented or that was adjacent to me. None of them had—none. They all went to the suburbs. I was hopeful that they would settle in a medically underserved area that I represented. They didn't.

We have been struggling along with the National Health Service Corps and other ways to induce people to locate in the rural areas. I don't know that we have the answer.

You articulated 15 things, 15 reasons why it is tough to make it in the rural areas for a doctor. What are we going to do? I mean what other things are there out there that we can do to really get them to locate, because I have seen people out of the Health Service Corps come to the rural area 2 years and they are gone, they have done their duty. They tell me they are overwhelmed; they don't have the peer review, they don't have any relief. They are kind of afraid of nurse practitioners and physicians' assistants, that they don't provide the necessary oversight and therefore they are liable to be sued more often than people where there is peer review.

What do we do? Can you give me any suggestions?

Dr. HABERSANG. Well, I would have felt that that probably wouldn't work in the first place because it has not worked for a long time.

I think you need to look also and more so actually at the education system, per se. Where are educational programs? They are in large cities by far, and they are in tertiary hospitals, which means that the role models a trainee, be that a medical student or even residents, see the person who is the great guy, who saves everything, is the superspecialist. You can have all kinds of incentives. If the great guy is the one who is the specialist of your left toe then that's what people will emulate.

I think that until that is somewhat changed we all work for and toward idols and role models. If you see general physicians, be that pediatricians, not in academic institutions, as the ones who run the show but as the ones who are run, what do the residents and students think?

The other part is that in those institutions residents are trained at a level of technological medicine which never will be out there, but they are so dependent that they cannot make a decision or feel uncomfortable making decisions without having an MRI here and all these other things. That is a big problem.

I think rather than paying folks to go to medical school and come back to their home, I think every training program ought to have residents in their last year or 2 go for 3 months in a rural community, and when I say rural I mean 50 to 60 miles away from a place

where you can get everything, because, it is anxiety. I talked to one of my former residents who is scared to death at times because she was so used to all this stuff.

Chairman POSHARD. We are going to have to break. We have final passage of the interior appropriations bill right now, and there are 6 minutes left on the clock, so we will come back and go to Congressman Sarpalius's questions of this panel.

[Recess.]

Chairman POSHARD. We will resume the hearing with Mr. Pettry and Dr. Habersang.

Mr. Sarpalius has additional legislation that he is working on now himself, and he may not be back. At this time of the day it will be questionable as to how many Members will be able to return with all this going on, on the floor, and other things, so we will just proceed.

Let me just put one last question to the panel before we go to our next panel.

I think at last count I had about 26 health care reform meetings across my district, and in the last couple of months many of the people who have shown up at those meetings have said, "There is reform going on right now, Congressman; the debate on this issue has already spurred a lot of reforms in the health care community."

How are these changes that are currently under way affecting our rural health care system, in your judgment, and what kinds of changes, as practitioners in the field, do you see being prompted already even before whatever mandates may be coming down from the Federal or, in some cases, the State level?

Are you beginning to see some changes taking place as a result of this debate that is occurring now?

Dr. Habersang.

Dr. HABERSANG. Yes, we see changes right now, and I'm not sure that most of them are for the better.

The fact that we get HMO's and other group health type of organizations expanding from the city into rural areas really is difficult for the rural practitioners, because what they do out there does not necessarily fit with what the guidelines of these, quote, third party payer organizations are.

Example: Certain procedures are to be done by a specialist. Well, out in the rural practice, the family docs have done it for I don't know how many hundred years. The point is, now they don't get reimbursed. I think the inequities with regard to hospital reimbursement in the rural communities is going to kill them, and, as I stated before, what is going on right now, unless something specifically on purpose is being done, to look at incentives to keep health care at a level, at a functioning level, in the rural areas, we are going to lose much of what we have right now, as bad as in some areas it is.

Chairman POSHARD. OK.

You had mentioned in your testimony, Mr. Pettry, the necessity — I judged your words, that may not be accurate — but the necessity of universal coverage as opposed to just access. Why is that important to a hospital like yours or to rural economics in particular? Why is it important that we accomplish one as opposed to the other

because that is the philosophical notion that is driving the debate out here, universal coverage as opposed to access?

Mr. PETTRY. The universal coverage problem we talk about relates to Medicare and cost shifting. Medicare pays us 85 or 87 cents on the dollar, and the 13 or 15 percent that we don't recover from Medicare we shift it off on to somebody else. Well, when someone doesn't pay us anything because they don't have any money, we shift 100 cents on the dollar to someone else. So, we cost shift for Medicare 12 or 13 cents on the dollar. We cost shift 20 some cents on the dollar for each Medicaid patient, and for someone who can't pay their bill at all, we shift 100 cents on the dollar.

We need the coverage to say everyone is able to pay his or her share of the bill rather than moving these debts off on to someone else. It is important if we are going to deal with the issues of children who don't have health care, if we are going to have to deal with the issue of pregnant ladies who do not have health care and they give birth to malnourished children, if we are going to deal with the issue of elderly people or people in their fifties who don't have health care and who become long-term care patients on Medicare, because of numerous chronic illnesses, all of those things relate to universal coverage.

Chairman POSHARD. So it is not enough just to accomplish insurance reform or legal reform or get the pharmaceutical companies to be more just in their prices, we have to deal with the basic concept that everybody must be covered.

Mr. PETTRY. Absolutely. We provide coverage for our 450 employees. They would like to have health reform. It might lower their expenditure. It might not, but they would like to think that it would. But health reform will not make any net difference in the system once they have the reform insurance. It is all those who don't have insurance that we need to have health reform for.

Chairman POSHARD. Gentlemen, I thank you for being here. I appreciate it. Your testimony has been very helpful to us.

Chairman POSHARD. We will go on to the next panel at this point in time, and again I apologize for running so late here but this has been a busy day on the floor.

Mr. Jeffrey Human, director of the Office of Rural Health Policy, Health resources and Services Administration, Department of Health and Human Services, accompanied by Mr. Robert Van Hook, the executive officer of the Health Care Reform Office, the Department of Health and Human Services; Mr. Charles Fluharty, the director of the Rural Policy Research Institute in Columbia, Missouri, and he is accompanied by Dr. Tom Johnson of the Virginia Polytechnic Institute, and Dr. Bruce Bullock of the University of Missouri.

Gentlemen, we thank you for being here and for contributing to this committee's efforts today, and I think we will begin right off then with Mr. Human.

TESTIMONY OF JEFFREY HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT VAN HOOK, EXECUTIVE OFFICER, HEALTH CARE REFORM OFFICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HUMAN. Thank you, Mr. Chairman.

I am very pleased to have the opportunity to discuss the Health Security Act and how it will help improve access to affordable health care for the people who live in rural areas.

I am accompanied this afternoon by Mr. Bob Van Hook of the Office of the Secretary of our Department.

I would like to begin by discussing the problems rural Americans face today in securing health services and then how the Health Security Act will address these problems, and I have left a longer statement which I would appreciate being entered into the record.

Rural communities are suffering under the current health care system. They lack vital health care services and often the means to pay for them. More than 11 million rural Americans have no health insurance, including 18 percent of all farm families. Rural Americans who do have health insurance usually face higher premiums than other people because they usually have to purchase coverage alone or through a small business. The insurance that they have often does not protect them from the catastrophic costs that may accompany a severe illness. Most rural Americans work for small businesses that, if they offer coverage, offer no choice of coverage.

Physicians and other health care providers currently find few incentives to practice in rural areas. The fragile economies of rural communities and poor health insurance coverage provide little financial stability for rural health care practitioners and hospitals. Long hours and isolation wear rural providers out. The network of caregivers is stretched past the point of breaking. As a result, over 400,000 rural Americans live in counties without a single doctor and 34 million people live in rural areas with insufficient physicians to care for them.

Mr. Chairman, our Nation's health care crisis will not go away by itself. The Health Security Act seeks to fix what is wrong with the health care system while preserving what is right.

Under the act, every American citizen and legal resident will receive a health security card which guarantees private health insurance coverage that can never be taken away. The act creates consumer-run insurance pools called health alliances within the States through which individuals and families will purchase their insurance coverage. Health alliances establish a marketplace for health insurance that is local, rational, and consumer friendly. Insurance plans will compete for business on the basis of cost, quality, and services.

Further, because employees will choose their own health plans, their coverage will stay with them even if they change employers. It will be illegal for insurance companies to deny coverage or charge higher rates because someone is older, has a history of medical problems, or is self-employed or a small business owner. Em-

ployees and employers will share the cost of health insurance coverage under the act.

Most privately insured Americans now get their health insurance coverage through the workplace already, and the act builds upon this strength of our system. Employees who work for businesses with less than 5,000 employees will purchase their coverage through these alliances. Businesses with 5,000 or more employees will be allowed to self-insure as corporate alliances, as will rural electric and telephone cooperatives.

The act recognizes that not all families and small businesses will have the resources to purchase coverage. If they did, we would have universal coverage today. So, the act provides premium discounts for low-income or unemployed families as well as for small businesses employing low-wage workers.

Everyone will have a choice of health plans and doctors. Families will be able to follow their doctors and nurses into a traditional fee-for-service plan, a network, or preferred provider organization or into a health maintenance organization. The President's plan also preserves Medicare for the elderly and even expands benefits by adding prescription drug coverage and a new community-based, long-term care program.

So, that is how the Health Security Act works. It guarantees private insurance coverage for all Americans, makes health insurance company abuses illegal, offers families a choice of plans or doctors, and provides health benefits through the workplace, and preserves and expands Medicare.

The Health Security Act also speaks to the special needs of rural Americans in many ways. Through the health alliances, all Americans will be able to get the lower prices now available only to large groups, giving rural Americans better bargaining clout. Those who are self-employed, in businesses or farming, or are independent contractors also will be able to deduct 100 percent of their health care costs from their taxes compared to only 25 percent under the current system.

The act changes Federal funding of medical education to increase the number of family physicians and other primary care practitioners who have trained for rural areas. It promotes the full utilization of nurse practitioners, physician assistants, and clinical nurse midwives to help them better serve rural communities and authorizes sufficient Federal funding to greatly increase the numbers of those midlevel providers who graduate each year.

The act expands Federal National Health Service Corps loan repayment and scholarship programs to enable a great many more family practitioners to serve underserved areas. It doubles the Medicare bonus payments for primary care services provided by physicians practicing in rural underserved areas. It provides significant new tax incentives to attract providers to underserved areas.

For example, rural primary care physicians who begin to serve underserved areas may receive as much as $60,000 in tax credits over their first 5 years of service. Nurse practitioners may get up to $30,000 in tax credits over the same period.

The act provides grants for communities to form community health plans and networks, enhancing their ability to compete in

the new system and to maximize their control of their own destiny. It provides loans and loan guarantees to help capitalize programs serving low-income parents in underserved areas including construction, renovations, and conversion of facilities to more appropriate uses, and it provides grants to public and nonprofit entities to provide services that overcome nonfinancial barriers to care such as transportation, outreach, and translation and interpretation services.

In conclusion, there is, in my judgment, a public consensus and a political consensus throughout this country on the need for health care reform. The Health Security Act is in one sense a conservative plan in that it attempts to preserve the American health care system we are all used to but to improve it as well. In another sense, the President's plan is bold with the scope of benefits it proposes and the dream of universal coverage that it realizes.

The flexibility of the President has raised national hopes for the passage of meaningful reform. We have done our best, he seems to say, and we can live with a changed plan if it encompasses comprehensive benefits and universal coverage.

The plan he has introduced also takes important steps in reaching out to rural Americans with special provisions to bring to rural areas the health care that will make the plan work for them as well.

[Mr. Human's statement may be found in the appendix.]

Chairman POSHARD. Thank you, Mr. Human.

We will continue then with Mr. Fluharty.

TESTIMONY OF CHARLES FLUHARTY, DIRECTOR, RURAL POLICY RESEARCH INSTITUTE, COLUMBIA, MISSOURI, ACCOMPANIED BY TOM JOHNSON, VIRGINIA POLYTECHNIC INSTITUTE; AND BRUCE BULLOCK, UNIVERSITY OF MISSOURI

Mr. FLUHARTY. Thank you, Mr. Chairman, and let me commend you and this subcommittee for this hearing, congratulate you on your new role. I appreciate this being your first hearing.

Chairman POSHARD. Thank you.

Mr. FLUHARTY. The hour is late, and I would ask that my full statement, as well as the reference document relating to the work of our expert panel on economics, be included in the record. I would like to make several key points.

Chairman POSHARD. Without objection.

Mr. FLUHARTY. Thank you, Mr. Chairman.

This panel is an outgrowth of a request by the Rural Health Care Coalition to look at a number of specific questions regarding H.R. 3,600. Pursuant to that, many additional requests have come in from the policy arena, so we essentially have two national panels of experts within the university health policy and health delivery communities working in an ongoing way to provide decision support regarding the specific rural impacts of reform. Today we have Dr. Bruce Bullock and Dr. Tom Johnson from the economics panel joining us.

Let me briefly say that more people live in rural America than ever have. So, when we say rural is unimportant, it is probably more important than it has ever been; 52 million Americans live out there.

Let me also add that last week we completed a poll with the Gallup organization that showed 70 to 90 percent of all Americans support doing something about the needs of rural Americans in terms of health reform, and those are specific and unique issues.

I think that is the critical component of H.R. 4555 that we would like to emphasize. Regardless of what occurs, if we do not take into account the critical issues raised by Congressman Stenholm, Congressman Roberts, you, and other cosponsors of H.R. 4555, rural America is not going to be adequately addressed in reform.

I would like to review three reasons and suggest four issues that legislators should look at. First of all, the uniqueness of rural places, which we have mentioned; second, the fact that diversity in rural America means that catchall will not work; and, third, rural Americans know how to make decisions and implement change for themselves. If given a chance, they will create unique systems that work, and we would urge your support for this landmark cutting legislation you have before you.

I would like to raise four points that are critical in reform which reflect the consensus of our two panels. You are going to have to remember the unique composition of small business in rural America as you examine these.

First, there is a much larger proportion of small businesses in rural than urban America. Businesses with under 25 employees, self-employed individuals, low-wage job earners, and individuals who cannot purchase insurance through an employer assistance program. That is critically important.

Second, we need to understand the specific secondary effects of health reform on rural America. I will mention four issues. Mandates and universal coverage; there are radically unique secondary effects in these proposals. Second, the entire issue of Medicare. Third, cost containment issues. Four, the community rate question. If we do not think about these secondary effects, we will miss a major opportunity to think about those 52 rural Americans before negative change impacts them.

Third, Mr. Chairman, transition is the critical issue. There are critical transition issues in reform that, regardless of what occurs, we need to address. As your prior panel indicated, we are seeing major systemic change even as we speak. The great suburban sucking sound is already going on, and it is a major transition issue that both of our panels have identified and this legislation must addresses.

Fourth, rural communities need to be empowered to do their own work. Flexibility and the uniqueness of place must drive what occurs. So I know this panel today is seconding what has gone on before, and I know it is your concern, Mr. Chairman. I think this legislation allows flexibility at the local level. That is where we need to look.

Last, I would talk about the approach our panel is using and then invite questions. We will have an interim report to the Congress in mid-July, with the final report in September. This is a rather major analysis. As in all rural data and rural research areas, we tend to be very secondary to policy, so building that base is difficult.

The panel is looking at four impact areas that define rural communities-households, the full business community in rural America, the health service business community, and local Government. The analysis will look at those four components, as our matrix shows in your full research document, and we hope to have an interim report to you on that analysis in July, with a final report after recess.

We thank you very much for the opportunity to be here and very much commend the sponsors of this legislation. We think it is critical to rural America.

[Mr. Fluharty's statement may be found in the appendix.]

Chairman POSHARD. Thank you, Mr. Fluharty. We appreciate it.

If we can just kind of talk about this now, I would really appreciate it. I don't want to go formally back and forth with questions, but I want to get your opinions or your viewpoints on some of the things that concern me.

When I have my rural health care meetings and go out and talk to the people in the rural areas about health care reform, two things come up at every meeting, employer mandates and the whole idea of the regional alliance system that the President has proposed in his legislation.

Now tell me what you think about that, because in your research you are saying to me that the key differences in rural businesses are that larger proportions of small businesses employing less than 25 people exist in the rural areas. Those are the folks that show up at my meetings and say, "We're going to close the doors if we have an employer mandate," or, "We are going to lay off people," and it is going to have an adverse economic impact on the community, so I have to weigh and balance that.

Self-employed people are worried about it, and yet when I look at the President's bill, it seems to me that there are a lot of positive things in there for self-employed people.

The low-wage jobs in our rural areas that you refer to, they are there. I would say a good 70 percent of the jobs in my district are small business jobs. We don't have a huge manufacturing base except in one end of my district. Those are minimum wage jobs a lot of times. Many of those jobs do not have benefits with them. So, we are asking people who make $6 an hour, tops, to pay for a $367-a-month premium, middle line health insurance policy. They can't even begin to do that.

How do those people get affected by all of this? I am very concerned about this sector's concerns. Are we going to lay people off? Is it going to have an adverse economic effect in areas where small business is the primary activity? And are the regional alliance systems going to help or hurt the rural areas that I represent due to the peculiar nature of that area — longer distances to travel, more elderly people, poorer people, fewer physicians?

How are the regional alliances going to play into that and help or hurt us not just from the perspective of medical care delivery but also from the perspective of the rural economy that I also have to be concerned about?

So, let's just talk about that, whoever wants to talk.

Mr. VAN HOOK. Well I haven't gotten to talk yet.

Chairman POSHARD. Mr. Van hook, OK. Bob, could you identify yourself.

Mr. VAN HOOK. Yes. My name is Robert Van Hook.

I would just like to say that in terms of the mandates, the people who Chuck and his folks have described as being the predominant rural business folks are just the people who receive benefits under the President's plan in terms of premium discounts; that is, small, low-wage businesses, and when you look at the smallest of the low-wage businesses that are paying minimum wage, the actual amount that they would be paying for full coverage for their employees would be somewhere around a buck or $2 a day, 15 cents an hour or something along those lines. It is not a whole lot of money.

As you may hear us say on several things, those numbers are open for discussion. The Health Security Act and all the other bills that are being discussed here are, in fact, open for discussion, and we are pushing for universal coverage, however we can do that, and there are a lot of proposals that are being made on that.

In terms of the alliances, the real reason for alliances, again, they are consumer controlled, the boards of directors are, in fact, consumers or purchasers of care, and this is actually a way of organizing, reorganizing or reforming the insurance market.

If we are going to have the insurance reforms that we talked about, there needs to be a place where people can make choices and where those choices can be made apparent and where it can be easier by having everyone, all the insurance companies, working through alliances, that we can make sure that they are doing the right thing, that they are not continuing to do the things they have done before.

The other thing about alliances is, if you make alliances very small, if you say that only the small, very small, groups of 50, 100, 250, or 500 are allowed to be in a purchasing cooperative insurance pool, you run a very great risk of adverse selection. They may have to be much larger geographically in order to be large enough so that you don't have all the bad risks dumped into those pools.

It is a very touchy subject and a very difficult one, and again, there are a lot of discussions that are going on, and the President is certainly willing to talk to anyone about that, about the size or the composition or whatever else, and so I think there are a lot of discussions going on.

Chairman POSHARD. I think the President has been very open about discussing any modifications or changes, but I was wondering, in your judgment, if the folks that live in Clark County or Wabash County in my district who fear having to drive an additional 35 or 40 miles under a regional alliance system to access the health care they are getting now in their local community, is that a realistic fear?

Mr. VAN HOOK. I think on the contrary, Mr. Chairman, that the way the current system is structured, hospital closures are quite likely to happen because the industry is consolidating. Those hospitals that have four patients in them and 40 beds are going to have to make some changes, and right now there aren't very many provisions to help them make those changes, so they could end up in that situation anyway.

The alliances, on the other hand, actually will be able to assure that health plans get out to rural areas. They can provide incentives to health plans to move into underserved areas. States will have a lot of flexibility under the President's plan and under a lot of the other plans that are under discussion. States will be able to require health plans to go out into underserved areas.

So, I think with the combination of sticks, with requirements from the State, and carrots from the alliances actually could see some improvement in the variability of both coverage and access in those areas.

Chairman POSHARD. OK.

Mr. HUMAN. I would just like to add a little bit to that too. It seems to me, Mr. Chairman, if we are really going to extend coverage and benefits to 37 million people who don't have them now, that one way or another the productive people in our society are going to have to pay for that. We can pay for it through higher taxes or we can pay for it through individual premiums that we pay ourselves in cost shifting, or we can pay for it through an employer mandate in which the cost is shared by employers and by people. It seems reasonable to me to take the latter approach, particularly when we find that 61 percent of all small businesses already offer insurance coverage for their employees and yet they are forced to compete in pricing the goods and services that they offer with the 39 percent of small businesses who don't offer that kind of coverage.

It seems to me to be less disruptive to the whole market if we try to work with that current system, particularly when the President's plan limits the percentage of payroll severely in the case of small businesses with low-wage employees to 3.5 percent of payroll.

So, to me that seems like a way that we can go, if we decide to accept this responsibility, for giving everyone this kind of protection. I think that members of the middle class want this kind of protection almost as much, from what I have seen in talking about this proposal across the country, and including in your district, sir. I think they want this almost as badly as people who don't have health insurance now because people are so painfully aware of how easy it is to lose coverage once you already have it and how that can wipe out a person's life-style very quickly.

Mr. BULLOCK. I don't think there is any doubt but what there are some very substantial potential benefits from alliances, community rating kinds of processes. I think what is critically important is that rural communities and rural individuals be present at the table when those boundaries are defined and drawn and I think inclusion of people in that kind of discussion.

I think, second, we need to think very seriously about the transition, as Chuck mentioned earlier. If we allow these kinds of things to evolve over a 2 to 3-year period, we let the very substantial local ingenuity come into play in adapting and adjusting to those kinds of changes, if we set targets that are reasonable and attainable over these kinds of periods of time.

I think Mr. Stenholm mentioned bottom-up kinds of activity. I think that is critically important. As you begin to look at the recognition that things have to change, there clearly will be some very positive benefits both to individual households in terms of access

to health care, the potential generation of economic activity in rural areas as we expend additional resources for health care in those rural areas. That, of course, suggests some very substantial restructuring of the rural health care delivery system, as has been mentioned all afternoon by several people.

Adapting to change is, I think, something that rural America is very good at as long as they are at the table in that discussion, and I am very encouraged by the kinds of things we have heard this afternoon to suggest that people are indeed, people in your position and elsewhere, are very seriously concerned about how rural people will be affected by these kinds of things.

Chairman POSHARD. You don't necessarily then see a conflict between what is being discussed out here from the Federal perspective of implementing a new delivery mechanism for health care and Mr. Stenholm's suggestion on bottom-up reform?. You think it is possible to integrate those two approaches?

Mr. BULLOCK. I think it is a very constructive dialog to have everyone concerned at the table involved, allowing for those very different regional differentials not only between rural and urban within a State but between States and those kinds of things.

I think it is critically important that we recognize that spatial distribution of people, i.e., population density, is a very, very important factor, and certainly in West Texas we have been hearing some discussion. It is a very critical dimension of the thing. It just has to be brought to the table.

Chairman POSHARD. OK.

Mr. FLUHARTY. Mr. Chairman, just let me add that most economists would agree the CBO scoring of 3,600 indicated that 100 percent of that would be passed eventually to employees. Other studies have indicated 80 percent. I think when we do our analysis we will probably take the 80 percent figure.

The important thing to realize is that an insurance dollar generated in a network in a rural community such as H.R. 4555 suggests remains in that community, and I think part of the concern of this economics panel is how do we appropriately develop an analytic to score that, but we are trying to do it for you.

Chairman POSHARD. Mr. Fluharty, explain that to me. What this study suggested was that if we go to employer mandates, 80 percent of that cost to the employer will be passed on to the employee?

Mr. FLUHARTY. The CBO scoring indicated perhaps 100. An Urban Institute study indicated about 80. I would ask Dr. Johnson if he would like to comment on that, as he has done a lot of work with Virginia communities on this very issue.

Mr. JOHNSON. Mr. Chairman, generally from the view of an economist, given enough time the negotiations between the employees and the employers will revolve around the entire compensation package, and given enough time to respond to the changing circumstances the total compensation package will not be changed a great deal by whether the employer or the employee pays themselves for the insurance.

So, therefore, if you mandate the employers they will simply, given enough time and the opportunity, if they survive the process, they will in some way readjust their compensation package so that

the employees are essentially accepting a lower direct compensation and a larger indirect compensation.

The other thing to keep in mind is that if the employees are buying their own insurance, they are not made worse off accepting a lower net take-home, and in fact, when you consider the differential treatment of self-employed and employed, it can create a more equitable situation.

Chairman POSHARD. How are we actually helping the employee then if what we are looking at merely is a cost shifting over time to the employee from the employer? How are we actually helping them, because it really is cost that is at issue here.

I mean I fully accept the fact that we have qualitatively the best health care system in the world and even though access is a problem in some areas people even without insurance have access to our system. Usually it is through the emergency room of the local hospital, which is 10 times the cost for us, and that is problematic.

But the real bottom line here is, if we don't draw down the cost of health care for the Government for those for whom we have responsibility as well as for the American family, we are failing the people of this country.

When I look at the statistics that we have been given at least, the average family last year spent $367 a month for a middle line health insurance policy. You add a $500 deductible to that, an 80/20 copayment, 1.45 percent of our Federal income tax is Medicare tax, and then part of our State income tax is a Medicaid tax. Those five things together — premiums, copayments, deductibles, Medicare and Medicaid taxes — run the average American family $6,700 a year. Nobody can afford that.

So, how are we helping then the average worker who is the head of those families? How are we helping them by cost shifting from the employer to the employee in an employer mandate? I don't understand that.

Mr. JOHNSON. Well, one view is that by introducing the insurance through the employer it is a vehicle that perhaps allows through group discounts to get a lower insurance rate for those individuals. Now certainly that is more true of large firms than it is for small firms and in fact, is probably the underlying reason why so many larger firms are much more likely to have insurance for their employees than small firms, because they are able to pass on benefits, to share benefits between themselves and their employees that they receive from the volume that they get. It is not so likely in small firms, but it is a mechanism in doing it.

Another view is that in order to achieve universal coverage and the benefits that will come from that, you need a vehicle that is as inexpensive or efficient in achieving what we economists call the transactions cost, the costs of getting the job done, and that may be easier to deal with a limited number of employers than a very large number of individuals.

Chairman POSHARD. So then at least we are accomplishing coverage, and we may very well be accomplishing lower cost even though it may not all be absorbed by the employer.

Mr. JOHNSON. That is right. Our ultimate goal perhaps is then to bring down the entire cost of the program so that those benefits can be shared. As we have heard from the panelists before us, cost

sharing makes someone pay for all those costs, and in many cases the incentive systems are distorted by the way in which we are asked to pay for those costs, so that we end up choosing a mechanism for our health care that is much more expensive, and so if we can reduce the entire cost through the savings and more greater efficiencies everyone could benefit from the ultimate package.

Mr. FLUHARTY. Mr. Chairman, if I could offer one more thought.

Chairman POSHARD. Yes.

Mr. FLUHARTY. I think it is critical to think about this question in terms of the rural community where all those people live, the doctors, the hospital, the family that has no insurance, the family that is in a low-wage-earner situation with minimal insurance, poor benefits, and a child at risk, the family that has good insurance but is at this point in a situation where their hospital is trying to deal with these other issues and, frankly, the employee who has good health care and may pay more. The reality is, this isn't Fairyland, and I believe we must think about the full synoptic impact on the rural communities in your district. Our sense is, if we take that approach, it is to the betterment of those communities that this occur.

Chairman POSHARD. Very good.

That leads into the concern that I have, and I want to get away from the guy, the mom and pop operation down on Main Street for a moment. When I look at Mr. Pettry there, his hospital is probably the biggest employer in your community — the second biggest employer. The hospitals in most of my communities are the biggest employers. So, he is in a situation where 70 percent of his case load — and I think that is average throughout my district — are Medicare, Medicaid eligible people. Only 30 percent are private pay people. He is losing money on both Medicare and Medicaid, which is 70 percent of his case load, so he is having to cost shift over to the 30 percent private pay to stay alive.

How are we going to help his situation with health care reform? because he is a big employer in my district. Every hospital and all of the medical care community combined by far exceed jobs produced than any other industry in my district. How do we keep him fiscally solvent through health care reform? because that is what, bottom line, means jobs to me too.

Mr. VAN HOOK. We couldn't agree with you more.

If I may say one thing about shifting from employer to employee, we are in a new world. This is a historic time, and if we do health reform right and do universal coverage, this is going to happen to all those small businesses at about the same time. That gives them an historic opportunity and one that is unique and very hard to predict by hindsight. It gives them an opportunity to actually raise their prices a little bit, and some of those businesses are of the types that can raise their prices to compensate for that, and their competitors in the next town will be doing that as well.

But back to rural hospitals. I think there are several things that we can do for rural hospitals. Number one is, get rid of the $1.5 billion or so a year that they absorb or pass on to someone else in uncompensated care. I think, two, we have to realize that this new money is going to mean expanded services and expanded demand on those facilities, particularly the ones that are successful, and I

think even for the ones that aren't going to be successful in the long run, that just don't have the economy of scale and the capacity to deal with the new order, even without health reform, I think we have to realize that in those communities when a hospital closes and closes — or converts into another kind of facility and that we use the bottom-up approach to develop a set of health services to meet the needs of that community and design, you don't have to lose that many jobs, you might not have to lose in jobs. You may, in fact, find that there are other services that are more labor intensive than having a full scale x-ray unit in town, and so you may actually be able to employ more people. I think it is a matter of good planning and sound economics.

In a lot of cases those rural communities — we were talking about this before — are putting in a lot of money. They are anteing up $600,000 a year, $1 million a year, in property tax money to support these facilities that aren't terribly productive for those communities.

So, I think there are ways that one could shift those around. But I think a bottom-up approach a is good one, and that is why the President's plan has a whole series of initiatives in there that would do that and to help them develop their flexible capacity expansion programs to help them develop networks in a variety of ways, and just as Congressman Stenholm said, we need to think about inner city urban and rural in a lot of the same ways because they are both places that are not resource rich in terms of health care resources, and that takes a different kind of approach, and we think that with a flexible program we can meet the needs of both.

Mr. BULLOCK. It would suggest that a lot of attention needs to be paid to what are reimbursable expenses, who qualifies for reimbursable expenses, and how those levels of reimbursement are calculated.

Chairman POSHARD. OK.

Mr. JOHNSON. Mr. Chairman.

Chairman POSHARD. Yes, sir.

Mr. JOHNSON. Regarding the role of hospitals or, more generally, the health care system in rural areas, in rural Virginia I concur that in many cases the hospital is usually the second largest employer after the school system, but they play a much broader role than that, and it is important to keep that in mind, and if we think instead of hospitals, if we think of the role of the health care system, a good, well planned health care system is critical to the future of rural America because, without that, many of the strategies that rural communities are now looking at for their future, including retirement places, including tourism places, including places where high-quality jobs are attracted, those things will not occur at all without a sound health care system, so that by — without improving the access to health care, and not necessarily hospitals because perhaps there are ways that communities can collaborate with neighboring communities to provide a more efficient health care system but one that meets the needs of area, without that, many, many communities have very few, if any, alternatives left.

Chairman POSHARD. I agree with you 100 percent. I have spent a lot of time in economic development, and I know when you are looking at a prospective industry moving to a community or trying

to locate in a community, once you get past sewer systems and water systems and roads, health care is about next in line, and education.

Mr. JOHNSON. Let me stress how important this is to urban America as well. Urban America is increasingly looking to rural America as a place for recreation, as a place for people to look after the resources that are so important of water and natural resources, and without a sound economy in rural America those opportunities for rural recreation opportunities, and so on, and tourism, are simply not going to be as satisfying to rural America, and as well, rural America wants to contribute to the common good of the country just as much as urban America, so it is in the entire Nation's interest to see that rural areas have a high quality of life.

Chairman POSHARD. Well, I appreciate that, and that is why we formed the Rural Health Care Coalition to begin with, because we don't want to be left out of this debate. It is very important that we have that kind of accessible, quality health care, or it affects our economy in other ways. We don't get jobs in the rural areas without it.

I just have one more question. We are running real late here, and I'm sorry to delay you, but, an important part of the Rural Health Care Coalition bill, Mr. Stenholm and Mr. Roberts's bill, is its antitrust section.

When I talk to my hospital administrators and others who are impacted by health care in the rural areas, they tell me that because of antitrust provisions in the present law they can't cooperate in ways that they would like to. They can't get across those artificial boundaries I talked about unless we strike some of those things. We are attempting to do that. Is that good? Bad? What does it do to consumer protection? Does anybody have any reservations about it? Just give me your ideas on that and whether you think we should be doing that or attempting to do that.

Mr. FLUHARTY. Our other panel, Mr. Chairman, spent a great deal of time dealing with that question. I think the centrality of the transition issues is key. When we are in a system where people wish to collaborate and cooperate and people are not seeking to gain competitive advantage because, frankly, there is no competition, it is much less of an issue.

To the extent that there is a differential impact as a result of those changes in the broader health care service system, we have again created an unintended transitional problem that we were not aware of at the start.

But the other panel spent a great deal of time dealing with that issue and feels very strongly that it won't move forward unless we address that and that it definitely needs to be done. The economics panel has not dealt with that question yet, but they are trying.

Chairman POSHARD. OK.

Mr. VAN HOOK. Mr. Chairman, may I make a comment on that?

Chairman POSHARD. Yes, sir.

Mr. VAN HOOK. We have taken a brief look at the legislation that has been proposed, and I thoroughly and deeply, from personal experience, recognize the issues that are involved here. The Department of Justice and the Federal Trade Commission came out last September with some new guidelines that set up safety zones, and

within those zones of activity nobody is going to get prosecuted. They also set up some scenarios that describe some of the activities outside of the safety zones that might be OK.

But they also established a mechanism for an expedited review so that if people want to do something collaboratively, they can get an answer in very quickly. I understand that in fact, they are getting those answers out, and if you do what you say you are going to do on paper when you write your question in, you are protected, you are safe, you have a harbor.

I think a lot of times rural providers are a little afraid of getting into this area. I think we have to remember, though, why the antitrust legislation was set up. It was to protect consumers from being at the beck and call of business We have to make sure that consumer interests are, in fact, protected. Unfortunately, this legislation would cut down a check list of about 15 or 20 things down to about four or five things, most of which would greatly benefit providers. I think that may hurt consumers, and we just need to look at it in a very balanced way and make sure that we are doing it the right way.

Chairman POSHARD. Those 21 things being consumer protection devices in the law right now, and it would cut those down, in your judgment, to five or six?

Mr. VAN HOOK. Yes, sir.

Chairman POSHARD. OK. But you are saying that the administration has made some provisions at this point for rural medical care providers to begin cooperating in a way that strikes these antitrust provisions as long as they are not affecting competition?

Mr. VAN HOOK. I'm saying that in the joint statement that was issued in September it is not a total fix, it doesn't just open it up and say anybody can get together for anything. But we have to realize that if two hospitals get together that are, say, 30 or 40 miles away and they decide that they are going to close the obstetrics service in one of the hospitals, that means that mom X over here in the town that doesn't have the obstetrics service any more could be disadvantaged. I know we drove 45 miles to the hospital when I was living in Virginia when we had our second kid, and my wife almost didn't make it there. I know how difficult that is. That is just an example of how we really have to be careful when we are thinking about relaxing consumer protections.

If every provider in the area is together in one economic unit, who sets the prices at that point? Can there be any cost containment? One of the things I think they found in California with the Calpers system is that those rural doctors that are out there in those small communities have a big leverage because they are the only game in town, and that could be a large economic unit if those were larger economic units of multiple hospitals and multiple doctors. Maybe I am not making the right point for rural advocates, but I mean it would be very difficult to contain costs if there is not some kind of competition.

Chairman POSHARD. I can see your point, but there has got to be some middle ground there that we can find to enable us to stay alive in those hospitals without impinging upon consumer concerns too greatly.

Well, gentlemen, as you heard the bells a couple of minutes ago, we are into another vote, the rule on Commerce, State, and Justice, and so I am going to have to go, but let me thank you very much for being here and making a contribution to our effort. We want to continue to work with you, and we are anxiously awaiting your report in July. I think that will help us a great deal with respect to how we work with the administration in terms of ironing out some of these problems in rural health care.

Thanks very much, and I appreciate your being with us.

The committee hearing is adjourned.

[Whereupon, at 4:36 p.m., the subcommittee was adjourned, subject to the call of the chair.]

APPENDIX

Rural Health Care Reform

The health care reform question facing this country today is a tough one to answer, and I can guarantee that the new Administration and Congress will be battling with the issue of health care reform for years. Rural health care must not be left out of the comprehensive health care reform package. For this reason, I have joined with some of my colleagues in Congress and have become a member of the Rural Health Care Coalition, and I am also a proud cosponsor of House Concurrent Resolution 69. This legislation will insure that rural health care will be a part of any Federal health care legislation.

Through my participation in the rural task force, we have developed a rural health profile and set priorities for health care system reform. The residents in this rural health care profile are about 25 percent of the total United States population, have larger percentage of senior citizens, and account for one-third of the total population living below the federally defined poverty level. This is unfortunate because our rural residents continue to be left out of the traditional employment-based health insurance system because a larger percentage are unemployed, self-employed, seasonally employed, or employed by small business. Moreover, these residents are subjected to more occupational hazards. Agricultural workers account for three percent of the workforce and 14 percent of the work related deaths. This pushes already high individual market premiums even higher.

The profile for health care providers is also grim. The lack of recruitment and supply of primary care physicians and other practitioners is especially acute in underserved rural areas. Rural health care facilities are also at a disadvantage. Due to the high percentage of Medicare and Medicaid recipients in rural populations, rural health care practitioners and hospitals tend to be more dependent of government revenues. This dependence on government payments often prevents reorganization of the facilities and services to better meet the needs of the population. They also suffer discrimination by the federal government with lower Medicare reimbursements because the bureaucrats assume costs are lower in rural areas. What they ignore is a simple lesson in Economics 101 - economics of scale. Rural providers cannot easily pass on costs to consumers because there are simply not enough of them.

To combat these problems, the members of the rural health care task force and I have formed coalition priorities to incorporate rural health care reform in a health care reform package. The first priority is to provide incentives for hospitals, physicians, and other providers of health care to participate in community-based systems of health care and networks. Rural health care systems should maximize the use of mid-level practitioners. These systems should also provide incentives to develop telecommunications systems and networks in order to provide greater access to education for rural

practitioners and for immediate consultation with specialists. Another important part of rural health care reform is to stress the importance of each state's unique characteristics. Reform efforts must allow the states flexibility to achieve a health care plan that is best for their community. With this type of reform flexibility, insurance proposals must assure geographic access to service in rural areas. Rural representation must be assured.

Using these priorities as guidelines, I will fight hard to see rural health issues become incorporated into my draft of a comprehensive health care reform plan. According to the people of the 16th District of Illinois, the dominant points in the health care reform package are (1) allowing individuals and their families to remain free to choose their physicians and insurance plans (2) controlling health care costs by promoting consumer choice and competition, and (3) the introducing "Medisave" accounts that will work as a savings account.

The freedom to choose physicians and insurance plans is an important component of the total health care package because it promotes healthy competition among physicians and insurance companies. Families would "shop around," to compare the premium prices and benefits of rival plans and making their choice accordingly, just as they do for life, car or home owner insurance. Families would still save money by choosing the least expensive plan that meet their needs. In turn, plan organizers would have to compete aggressively for the family's dollars by developing plans that combined attractive benefits with a good price. Precisely the same imperative keeps costs under control elsewhere in the economy.

The introduction of "Medisave" accounts will put each individual in control of how much he or she spends on health care. This is possible because a Medisave account is a tax-free personal account that is used to pay medical bills not covered by insurance. Regular deposits can be made by individuals or their employer, but are the property of the individual. Money can be withdrawn without a penalty only to pay medical expenses. Money not spent grows tax free and may be used for medical expenses after retirement or rolled over into a private pension plan.

Medisave accounts ensure that people will have money to pay small medical expenses, including expenses for preventive care, and to pay insurance premiums if they change jobs or are unemployed. These Medisave accounts will also promote a competitive marketplace by giving patients and their physicians an incentive to make cost-effective decisions. I will fight to preserve quality in health care service and to maintain affordability.

Last but not least, we cannot forget that it is essential for Congress and the administration to cut unnecessary and wasteful spending. Any additional federal spending to expand access to health care or medical services should be financed by reducing spending in other areas of the federal budget - not by tax increases!!

Information on "Medisave" accounts by National Center for Policy Analysis (NCPA),Dallas, TX.
Information on "Consumer Choice", by The Heritage Foundation, Washington, DC.

STATEMENT BY REP. GLENN POSHARD
SUBCOMMITTEE ON RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT
JUNE 23, 1994

Thank you for coming to this hearing of the Small Business Committee's Subcommittee on Rural Enterprises, Exports, and the Environment. Our topic is "Health Care Reform, Rural Small Businesses, and the Rural Health Delivery System Development Act of 1994."

Various Congressional committee hearings have focused in recent months either on the small business or the rural aspects of health care policy. Other hearings have examined the broader economic implications of health care reform - for example, employment effects or competitiveness. At this moment, as we are in the midst of what is obviously a critical stage in health care's legislative process, I think it is important to take a last look at these topics together - before final decisions are made concerning a health care bill.

What I hope we can help determine today is to what degree rural small businesses, the rural health care delivery infrastructure, and the rural economy in general require special or additional consideration in health care reform.

The bipartisan Rural Health Care Coalition here in the House, of which I am a member, has looked long and hard at this topic. Our first panel will discuss the Coalition's main work product, H.R. 4555, the Rural Health Delivery System Development Act. The bill's two chief sponsors will explain its provisions, and we will ask today's other witnesses for their comment, as well.

As an original cosponsor of H.R. 4555, I share my colleagues' hope that its provisions can make their way into whatever health care bill ultimately moves to the floor this year. As a bill, or as a set of amendments, these provisions are a sort of yardstick by which to measure whether health care reform adequately addresses rural concerns.

The hearing also will consider the implications of health care reform for the rural economy. The problem of rural health care delivery has received much deserved attention, but we also need to know as best we can what the likely economic effects of reform will

be - both the positive and the potentially negative. The two major elements of reform - universal coverage, however we define it or whenever we reach it, and cost containment, however that is achieved - will have economic consequences in rural communities. The mechanisms we choose to pursue universal coverage and cost containment should be examined with particular attention to how they will affect the rural economy. Of course, failure to pass meaningful health care reform would also have serious economic effects, and knowledge of that fact is part of our equation, as well.

Our second panel consists of local experts. Harvey Pettry is the Administrator of Richland Memorial Hospital in Olney, Illinois, which is in my home district. Dr. Rolf Habersang is a pediatrician in Amarillo, Texas, which is in the home district of Congressman Sarpalius. These two gentlemen will discuss, among other things, the connection between what they do - they are practitioners in the health care delivery sector - and the local rural economy where they live and work.

Finally, I am pleased that we have with us Jeffrey Human, Director of the Office of Rural Health Policy at HHS. Mr. Human is accompanied by Bob Van Hook. They will present the Administration's views concerning rural health care reform, including how reform might affect the rural economy. I hope we can also get them to comment on the rural reform provisions suggested by H.R. 4555. In addition, we have Charles Fluharty, who is Director of the Rural Policy Research Institute (RUPRI). RUPRI has been conducting important economic analysis concerning health care reform and the rural economy, and I look forward to what I'm told will be a preliminary description of their findings here today.

OPENING STATEMENT
THE HONORABLE BILL SARPALIUS

Good afternoon. Thank you Mr. Chairman for holding this hearing and inviting our distinguished panels of witnesses to testify before our committee. I would particularly like to welcome Dr. Rolf Habersang, who is here from my district and serves on my advisory committee on health care reform. In addition, thank you to my respected colleagues, Charlie Stenholm and Pat Roberts, for their hard work to ensure better access to those living in rural communities.

Access to adequate medical care is difficult for many people across our great nation, but I believe it is particularly difficult for those individuals living in rural communities. Studies have consistently shown that many rural residents continue to be in poorer health than urban residents, and are more likely to be unable to afford adequate health care. They are less likely than urban residents to benefit from tax incentives and government spending programs aimed at making care more available and more affordable. Poverty, rural economic decline, the demands of an aging population, and geographic constraints further complicate health care delivery and financing.

The following information demonstrates the problem for rural America:

* 7.7 million rural people lack basic health insurance

* 26.5 percent of the rural uninsured are children -- rural school age children (ages 6-17) are more likely to be uninsured than their urban counterparts

* The rural nonelderly residing in the South are more likely to be uninsured than their counterparts in other areas of the country

* Rural workers are less likely to be insured than their urban counterparts

* 42 percent of the rural uninsured are working

* Nearly 60 percent of the nonelderly rural uninsured who are working are employed by firms with fewer than 25 employees

* 26.1 percent of rural agricultural workers are uninsured

The list is endless as to what needs to be addressed. We must get more primary care physicians into rural areas. Too few medical students want to go into primary care and too few primary care physicians want to go to rural communities. Why? Because they have large loans to repay and the big city practices are more lucrative.

In Texas, there are 23 rural counties without a single primary care physician, seven of these 23 counties are in my district. Believe me, I have heard from many of my constituents who do not have adequate access to a doctor. Many of these individuals do not have a hospital alternative for care either - there are 56 Texas rural counties without a hospital - 12 of which are in my district.

Undoubtedly, opening more rural hospitals is not the answer, as those that are in existence face serious financial problems. Small hospitals and those in poorer areas provide relatively more uncompensated care than larger hospitals or those in wealthier communities. As we know, most rural hospitals are small -- 82 percent of all hospitals with fewer than 50 beds are located in rural areas, and hospitals with fewer than 100 beds account for 72 percent of rural hospitals.

Access to quality medical care is more difficult for individuals living in a rural community. Today we are all anxious to find out and learn what we, as Members of Congress, can do to help these communities receive the care that they deserve.

Again, thank you Mr. Chairman.

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THE RURAL PERSPECTIVE ON NATIONAL HEALTH REFORM LEGISLATION

Addressing Rural Economic Impacts

**Reference Document in Support of
Testimony Presented to
The House Committee on Small Business
Rural Enterprises, Exports, and the Environment
Subcommittee**

RUPRI Rural Health Reform Economics Expert Panel

June 23, 1994

P94-6

For more information, contact:

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The Rural Policy Research Institute provides objective analysis and facilitates dialogue concerning public policy impacts on rural people and places.

This RUPRI briefing is published to inform public opinion, and provide a more informed policy debate. Views expressed are those of the Expert Panel convened for this purpose, and do not reflect the views or policy of any institution.

INTRODUCTION

This June 23, 1994, Hearing testimony before the Rural Enterprises, Exports, and the Environment Subcommittee of the House Committee on Small Business addresses the impacts of national health reform legislation on rural small businesses and the rural health delivery system. The Rural Policy Research Institute (RUPRI) has assembled two national Expert Panels to serve as ongoing research and decision support resources for policy makers throughout the design, implementation, and evaluation of national health reform. This testimony was develop by the Rural Health Reform Economics Expert Panel, a distinguished group of nationally recognized economists, assembled to analyze the rural economic implications of the national health care reform. Members of this Panel are listed below:

RUPRI RURAL HEALTH REFORM ECONOMICS EXPERT PANEL

Bruce Bullock, Ph.D., University of Missouri
Ralph Christy, Ph.D., Cornell University
Sam Cordes, Ph.D., University of Nebraska
Gerald Doeksen, Ph.D., Oklahoma State University
Mark Edelman, Ph.D., Iowa State University
Tom Johnson, Ph.D., Virginia Polytechnic Institute & State University
David Holland, Ph.D., Washington State University
Tim McBride, Ph.D., University of Missouri
Shirley Porterfield, Ph.D., Washington University
Ron Shaffer, Ph.D., University of Wisconsin
Ron Young, Ph.D., Kansas State University

A second RUPRI Expert Panel, comprised of national rural health policy health delivery experts, has analyzed the Rural Health Delivery System Developments Act of 1994 and the enclosed testimony includes reference to this analysis. Members of the this Panel are listed below:

RUPRI RURAL HEALTH REFORM EXPERT PANEL

Andrew Coburn, Ph.D., University of Southern Maine
Sam Cordes, Ph.D., University of Nebraska
Robert Crittenden, M.D., University of Washington
J. Patrick Hart, Ph.D., Northern Wisconsin AHEC
Keith Mueller, Ph.D., University of Nebraska
Wayne Myers, M.D., University of Kentucky

OVERVIEW

Mr. Chairman, distinguished members of the subcommittee, the Rural Policy Research Institute (RUPRI) appreciates your leadership in holding this Hearing to address the rural small business and economic impacts of national health reform.

As you know, contrary to popular belief, the population of rural America is not shrinking, but continuing to grow. Congressional decisions regarding health reform will profoundly impact the health of the approximately 52 million Americans living in rural areas, as well as the future of their health delivery systems and the rural economies which support both. We appreciate this subcommittee's attention to the impacts of health reform upon the rural health delivery system and the rural economy and rural small businesses which must adapt to the changes which will result from national health reform. In both cases, it is critical that eventual legislative outcomes are sensitive to the unique needs of both the rural health delivery system and the rural small businesses.

As you know, RUPRI has two distinguished national Expert Panels assessing the rural implication of health reform. Today's testimony is the product of the Rural Health Reform Economics Panel, which is concentrating its analysis on the impact of health care reform upon the rural economy and rural small businesses, rural households, rural health delivery systems and rural local governments. The second Panel has focused upon the rural health care delivery system during the past nine months, and is providing ongoing analysis for Congressional decision makers.

This Expert Panel testimony is based upon the critical analysis this group is developing in assessing the rural economic impacts of various health reform proposals. This Panel will release an initial assessment during a Congressional briefing in July, with final analysis expected following the August recess. However, this Panel is pleased to respond to your request for this initial review of their current work, to place these issues in a policy context and briefly review the critical issues regarding small business and rural economic impacts which are policy malleable.

The second RUPRI Health Expert Panel is focusing upon the rural health delivery system impacts of national health reform, and has provided analysis of the Rural Health Delivery System Development Act of 1994 during its development and review. We appreciate the leadership Congressmen Stenholm and Roberts are providing in addressing the unique health service delivery needs of rural America. The Panel's analysis of this legislation is available as a separate RUPRI policy brief, and will be referenced during our oral testimony.

Preliminary Observations and Comments
RUPRI Rural Health Economics Panel

The RUPRI Rural Health Economics Expert Panel has identified a number of critical concerns regarding the rural economic impacts of national health reform legislation. These observations highlight these key concerns, and are central to the analysis which this Panel is currently developing.

Health care reform that ignores the spatial distribution of people and/or the composition of businesses (size, type, industry structure, etc.) will likely generate unintended and undesirable differences in the spatial and social distribution of consequences generated by reform.

The spatial distribution of people and businesses (both type and size) is a critically important dimension of the U.S. society and economy that should be taken into consideration as health care reform legislation is developed. These spatial differences mean that the economic impacts (both positive and negative) will likely differ between urban and rural segments of a given state. Moreover, there will likely be substantial differences between states because of regional differences in (a) the spatial distribution of people and businesses, and (b) the current economic status of those people and businesses. Some key differences in rural businesses are the larger proportions of (1) small businesses employing less than 25 people; (2) self-employed; (3) low wage jobs; and (4) individuals purchasing health insurance without employer assistance. These differences mean that the economic impacts will likely differ between urban and rural segments of a given state and between states.

The transition provisions of proposed legislation are critically important. It is desirable from a rural business perspective to (1) allow the transition to occur over a 1-3 year period, (2) provide employers who do not currently provide health insurance, especially small and low wage businesses, with maximum flexibility to select and develop ways to achieve the target, and (3) establish targets that are reasonable and attainable over the adjustment period.

The short run (1-3 years) impacts of employer mandates and other provisions that increase business cost will likely be greater than the longer run impacts after businesses have been able to adjust to the new cost structure. Moreover, these impacts are likely to be greatest for firms that are not now providing health insurance benefits to employees. These impacts will also likely be particularly significant for small firms and firms with relatively low wage employees.

It is critically important that rural interests are appropriately represented in the process of determining the boundaries of community rating programs and health service purchasing alliances/cooperatives.

The determination of boundaries for health service purchasing Alliances and/or community rating programs will be crucial determinants of the benefits to rural citizens and businesses from health reform. Given that rural areas differ from urban areas on a number of important dimensions (as described above), it is quite possible that health insurance premiums would be higher in rural areas if these differences are not accounted for in the legislative process.

Proposed changes in either the magnitude of government expenditures on Medicare and other new benefit programs (eg. home health care and prescription drugs) or methods of program administration and reimbursement should be evaluated in terms of possible impacts on the rural health care delivery system and impacts on rural businesses and households.

Hospitals and other health related businesses in rural areas are disproportionately affected by changes in provisions of Medicare and other benefit programs (e.g. long term care and prescription drug coverage.) These businesses are heavily dependent on these programs for operating income. Thirty percent of rural hospitals have expenses that exceed income at the present time. Modifications in the Medicare program financing and operation will directly affect the economic viability of these businesses.

Not all rural hospitals will survive the transition to new health care programs. Reform should focus on the redesign of the rural health care delivery system, to provide flexibility, network development and the technical assistance necessary to reconfigure rural health services to meet local needs, as these rural institutions are integrated into the more complex and more costly health services that often can most economically be delivered in urban areas. This may have significant implication for rural businesses and households in terms of jobs and income.

If properly structured, health care reform legislation that stimulates and/or expands appropriate investments in the rural health care delivery system could improve the overall business climate in rural areas, and sustain or expand the number of health care sector jobs and linkages to the broader economy, as well as improve access to quality health care services. Rural health care businesses are an important provider of jobs and business The legislative challenge will be to stimulate and support both the redesign of the rural health care delivery system and the economic viability of the new system. Those rural hospitals that cannot survive may need to be converted into different health care delivery organizations that have an economic reason for existing.

Employer mandates are a key component of several reform proposals, with the potential for major direct and indirect impacts on non-health related businesses. Adjustments to an employer mandate are likely to be greatest for businesses that presently do not provide insurance, as well as other rural and small businesses which lack flexibility to adjust to the mandates.

In 1989, over 94 percent of firms with 25 or more employees offered health insurance, as compared with only 39 percent with fewer than 25 employees. (CBO, 1994) Employer mandates will disproportionately impact the small business community, and a disproportionate share of the businesses in rural America are small businesses.

One key issue is whether these businesses will be able to pass the adjustment impacts forward to product prices or backward to factor prices. A consensus opinion of economists is that about 80 percent of the costs of the employer mandate will be shifted to employees (Loprest 1994). CBO estimates presume this percentage or higher is eventually shifted to households. The Panel suggests the ability of businesses to pass on the impacts of employer mandates may very, depending upon the unique characteristics of each firm (e.g., size, type, and market conditions). Therefore, differential impacts may exist and the full extent of these impacts may not be known until reforms are implemented. In response, policymakers may need to develop a range of business monitoring, training, and adjustment assistance provisions to mitigate problems likely to develop, and to detect and resolve problems as they arise.

It is very important that reform legislation assure flexibility for states and local communities in adapting to their own unique circumstances.

There are clearly several economic and demographic differences between rural and urban areas within and between states that will create differential economic impacts under alternative reform proposals. Moreover, rural areas are very diverse and all have adapted to the challenges of health service delivery in unique ways which reflect specific local circumstances.

The legislation should recognize and account for the different economic impacts on state and local governments, both between and among states, and subsequently between rural and urban residents.

State and local governments will be given expanded responsibilities for design and operation of the reformed health care delivery system under most, if not all, reform proposals. This may require redesigned and/or expanded budgets and methods of revenue generation at the state and local level. The vehicles available for revenue enhancement differ substantially between and among state and local governments, which will add to the differential impact of national health reform.

In the effort to control national health care expenditures, it is important that the specific cost control mechanisms adopted have neither (a) an inherent bias against rural health care providers, nor (b) place the rural health care system and the larger rural economy at substantial risk.

The long term benefits of health care reform will be realized only if health care costs and expenditures are brought under control. Consequently, the success of managed competition, purchasing alliances or cooperatives, and other approaches to cost control are some of the most critical dimensions of proposed health care reform. But these benefits from the cost containment provisions will be helpful to rural areas only if the provisions explicitly account for the pressures forcing rural health care providers and businesses.

Analytic Framework

The preliminary observations contained in this report will be expanded and refined in a much more comprehensive study to be released following the August recess. An initial review of this analysis, in process, will be delivered via a Congressional Briefing in July.

This section provides the subcommittee with more detailed information on the key research questions and analytic framework that will inform this study.

To accomplish its purpose, the panel will:

(1) Identify and articulate the key questions/issues regarding the rural economic implications of health care reform.

(2) Provide a conceptual framework (i.e. describe the cause and effect relationships) that is appropriate for addressing these issues, and

(3) Develop panel consensus regarding the expected rural economic impacts of proposed reforms.

Background:

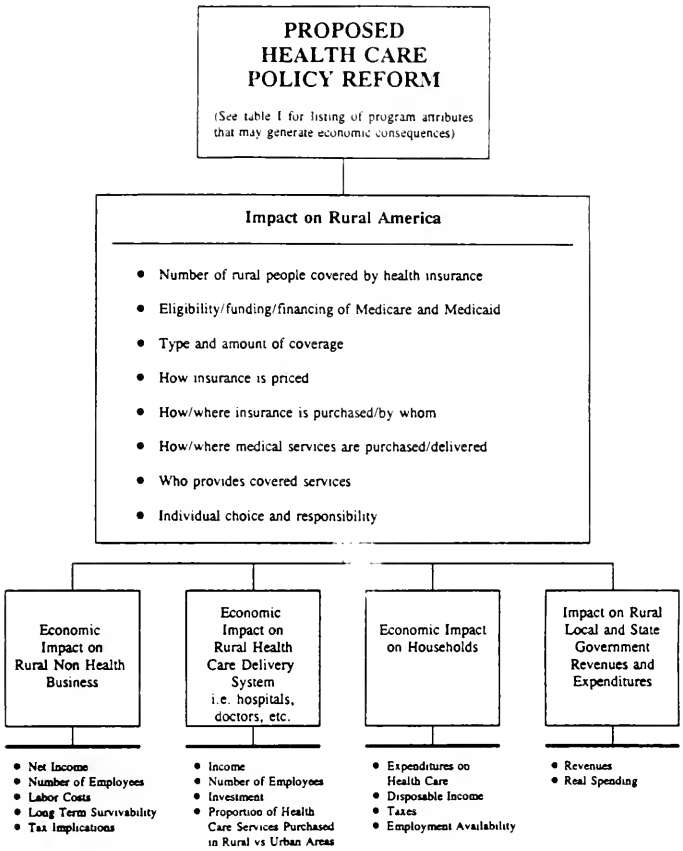
As you know, there are differences in several key economic and demographic characteristics that distinguish rural areas from urban areas that may generate a rural/urban differential in economic consequences of proposed health care reform. For example, compared to urban areas, rural areas tend to have a higher share of their respective populations in the following categories:

1. elderly people
2. small businesses employing less than 25 people
3. self employed individuals
4. relatively low wage jobs
5. individuals purchasing health insurance without assistance of employer
6. hospitals that are heavily dependent on Medicare payments
7. hospitals that have expenses that exceed revenues

Conceptual Framework:

The conceptual framework to be used by the panel in developing conclusions is depicted in Figure 1.

Figure I. Schematic Representation of Conceptual Framework Used to Evaluate Rural Economic Impacts of Proposed Health Care Policy Reform.



We believe you may also find this framework useful in your consideration of health reform proposals. The framework highlights that the economic impacts of health care reform will be realized in four segments of the rural economy.

1. Non Health Care Businesses
2. Health Care Delivery Businesses
3. Households
4. Local and State Governments

This analysis requires a clear specification of the particular attributes of a proposed policy change which can be expected to generate economic consequences, in addition to the intended enhancements in health care. These attributes are represented in Figure 1. by the box labeled "Proposed Health Care Policy Reform."

There are specific attributes of reform proposals that may generate a difference between the economic impacts of the reform in rural and urban areas. These are, in effect, the components of proposed reforms that may require particular scrutiny by individuals concerned about the rural economic impacts of the proposed legislation.

I. EXTENT OF UNIVERSAL HEALTH COVERAGE MANDATED BY THE PROPOSAL

The extent to which the legislation intends to achieve universal coverage and the proposed method of attaining universal coverage have significant economic implications.

II. HEALTH CARE COST CONTAINMENT

The long-term benefits of any proposed reform depend on how effective the program can be at achieving cost containment. Moreover, the rural/urban distribution of the benefits (perhaps costs) of achieving this control depend on the specific details of approach used to contain health care costs.

III. NATURE OF PROPOSED CHANGES IN MEDICARE

Rural hospitals and rural households are likely to be particularly affected by changes in provisions of Medicare. The nature of proposed change in either the level of funding or the administration/implementation procedures will be particularly critical for rural businesses, households, rural health care businesses and state and local governments.

IV. NATURE OF DETERMINING INSURANCE STRUCTURE AND RUSK SHARING

The details of how and where boundaries for community rating processes are drawn will be particularly critical for rural areas.

V. ORGANIZATION AND STRUCTURE OF HEALTH CARE INDUSTRY

Similarly, the details of how and where boundaries of health care service purchasing organizations are drawn will be of particular concern to rural America.

VI. ROLE OF GOVERNMENT

Finally, the distribution of responsibility for program development and management between the Federal, State, and local governments have the potential for substantially different impacts in predominantly rural areas relative to predominantly urban areas.

The baseline against which expected rural economic consequences are compared for each proposed health care policy reform is the current economic situation regarding employment, income, tax burden, etc., projected under the assumption of no change in current health care programs.

The box labeled "Impact on Rural America" is a listing of the first round effects on rural citizens of the proposed health care policy reform. These are the changes in the amount and nature of health insurance and health care available to rural citizens, and changes in how and where these services are purchased and paid for, which are likely to generate economic consequences that may be different in rural communities than in more densely populated urban areas. For analytic purposes, a specific response (answer) to these points will be developed for the specific reform proposal being considered. These responses will be compared to (and expressed as changes from) the current situation.

Given the information represented by the box labeled "Impact on Rural America," the analysis moves to an evaluation of the economic impacts of the proposed program. Economic impacts are generated through four components of the rural economy:

I. Economic Impacts on Rural Non-Health Businesses

Depending on the particular attributes of the proposed program being evaluated, the economic impacts on rural businesses differ between self-employed businesses and businesses with multiple employees. The economic consequences will take

the form of changes in the firms:

- net income
- number of employees
- labor cost
- long term survivability of business
- tax implications for self employed

II. Economic Impacts on the Rural Health Care Delivery System (i.e. hospitals, doctors, etc.)

Changes in (a) how Medicare expenditure trends are modified, (b) rural/urban reimbursement formulas for Medicare, and (c) organizational structure of the health care service purchase and delivery system, etc. will impact the rural health care delivery system through changes in:

- income of hospitals and health care professionals
- number of health care employees
- investment (disinvestment) in facilities and equipment
- the distribution of health care expenditures between the rural and urban health care providers

III. Economic Impact on Rural Households

A proposed health care reform program will impact the economic well being of rural households through changes in:

- expenditures on health care by household and on behalf of household members
- disposable income
- employment availability
- taxes
- cost of living

IV. Economic Impact on Local Rural Government

These forces will affect the economic well being of rural local governments by changes in:

- revenues
- real spending of local government

Time Line:

This RUPRI Panel is currently refining the conceptual framework they will use to score the expected rural economic impacts of the key health reform proposals currently under consideration by Congressional Committees of jurisdiction. As a starting point, these analyses will utilize Congressional Budget Office scorings, wherever possible. This analysis will evaluate rural/urban differences, if any, regarding key economic impacts identified.

An initial draft analysis, reviewing work in progress, will be presented during a mid-July Congressional Briefing. Following this Congressional input, a final report will be delivered following the August recess.

The Panel appreciates the ongoing dialogue which has developed with Congressional Members and staff, which will be reflected in our July Briefing document.

Small Business Subcommittee
on Rural Enterprises, Exports,
and the Environment concerning
"Health Care Reform, Rural Small Businesses,
and the Rural Health Care Delivery System Development
Act of 1994."

Hearing June 23, 1994

I. My name is ROLF HABERSANG, I am a pediatrician caring mostly for children with special health care needs in Amarillo Texas, a community of 165,000 people that also houses a Medical Center for a population of about 450,000 of the Texas Panhandle, the neighboring Oklahoma, Kansas, and New Mexico.

I have been in practice for 21 years of which the first 18 years were in academic pediatrics (three years in Kansas

and 15 years at the Regional Academic Campus of Texas Tech University Health Sciences Center in Amarillo). The last three years I have been in private practice in Amarillo, working with other pediatricians and Advanced Clinical Nurse Specialists.

Though most of my work is concentrated in Amarillo, I myself or a partner from my practice work with the Texas Department of Health and hold monthly clinics in outlying communities-- from 60 to 90 miles from Amarillo--as there are no pediatricians and travel to Amarillo is a hardship for many families.

I wish to discuss:

The impact of health care reform on

1. Rural health care delivery
2. Rural small business and

II. I reviewed concerns regarding heath care reforms with colleagues (mostly family physicians) from smaller communities who refer sick children to me:

Their Concerns are:

1. The shifting of health care services, even basic primary care, from the rural site to the city.
2. The manpower shortage and professional isolation
3. Reimbursement

Shifting of Health Care Services

With the trend of managed care and the development of larger groups, the need for primary care physicians as gate keepers increases. Because of the shortage of primary care physicians in general, the primary care physicians are also recruited from the small rural sites to urban groups.

This trend of rural primary care physician's moving to

urban cities will worsen the present man power shortage in those communities.

So let's look for a moment what impact manpower shortage has on the provider and the community.

Manpower shortage / Professional Isolation

Manpower shortage means that a primary care physician has to cover his practice not only during business hours from 8-5 but on a 24 hour basis more frequently than their counterpart in a larger community where calls can be shared with partners.

In addition to frequent night and week-end calls, the professional isolation concerns many physicians now practicing in rural communities. For example, a physician might want to obtain a consultation or simply discuss a

patient situation with a colleague, but can only do so over a long distance phone line. Therefore, a patient might be transferred to a larger city, at times unnecessarily separating families.

What could possibly prevent this patient form being transferred to the larger community?

If the rural physician does not only function in the primary care role but is also equipped to do secondary level care. This is a must for patients with chronic diseases. They cannot and must not go to the "big city" for care -- for consultations yes, but not for their monthly visit .

For this to happen, primary care physician must be better trained. In most residency programs this is not adequately address .... I could expand on this, but let me move on to

the next point which was mentioned as a concern voiced by my colleagues.

Reimbursement

The reimbursement issue has no doubt an impact on physician's decision to move to or stay in a rural community. Statistically, more people in the lower socio-economic strata reside in rural communities, that means the inequities in reimbursement by Medicaid and Medicare will compound the issue of retaining primary physician's in rural communities.

Manpower shortage and the problem of reimbursement result yet in another problem. Patients with insurance and private pay will be preferentially accepted by primary physicians over patients on reimbursement programs such as Medicaid. Thus leaving the poor without access to services.

(The "Gold Card" nobody wants!!). Or one could also say that in Texas "rural" remians nearly synonymous with "underserved."

III. Small Business / Economic Impact

Another impact of health care services to rural communities is ECONOMIC:

A practice model discussed in the Journal of the Oklahoma Medical Association, 81, (1988) p 568. estimates that a single physician practice in a rural community generates

- 17.8 jobs
- $ 343,706 income.

The availability of adequate health services is closely related to ECONOMIC VIABILITY. In 1992 the Rural Mayors ranked health services among their top five priorities -- above education and just below job opportunities and

economic diversification.

Lets remember -- Businesses do not locate in communities where health care services for their employees and their families are not available.

Health care providers then play a double role:

1. As providers of health care and
2. as small, but very significant businesses themselves.

IV. Recommendation

Health Care Reform and a rural health care delivery systems Act must then address and improve, not worsen the following:

1. Keeping the hospital
2. Keeping the primary care physician practicing "real

medicine", including more complex care, which in the city is provided by easily available subspecialists.

Present health care reform proposals do not specifically address rural health care needs.

If we fail to act, and address those needs, the loss of health care institutions and health care providers will diminish -- if not devastate -- business and life in rural America.
The reason I emphasized improving and not worsening the health care delivery status is because many programs were created with a "help" focus in mind, but have resulted in a worsening of the situation in rural America at least based on Texas data.

Reimbursement, licensing another federal and state rules and laws fail to recognize the reality of rural life in general --

RURAL MEDICAL PRACTICE IS DIFFERENT.

THOUGHT: For instance Hospital reimbursement inequity has resulted in closure of 51 hospitals in rural communities since 1985.

Thank You Mr. Chairman. I'll be glad to answer any questions you or your committee might have -- If I can.

Testimony of

JEFFREY HUMAN

Director, Office of Rural Health Policy
Health Resources and Services Administration
Department of Health and Human Services

Small Business Subcommittee on Rural Enterprises,
Exports and the Environment
June 23, 1994

Mr. Chairman and Members of the Committee;

I'm very pleased to have the opportunity to discuss the Health Security Act and how it will help improve access to affordable health care for the people who live in this Nation's rural areas. I am accompanied this afternoon by Mr. Bob Van Hook of the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

I'd like to begin this presentation by discussing the problems rural Americans face today in securing health care services and then discuss how the Health Security Act will address these problems.

WHAT'S WRONG WITH HEALTH CARE IN RURAL AMERICA

Rural communities are suffering under the current health care system. They lack vital health care services and often the means to pay for them.

- **Lack of Insurance.** More than 8 million rural Americans have no health insurance, including 18% of all farm families. Rural residents have higher rates of chronic or serious illness and many, especially those engaged in farming, mining, and other high risk occupations, face a constant and realistic fear that their insurance will be canceled if they get sick or have an accident. These workers often cannot get further insurance because they now have a "pre-existing condition."

- **High and Rising Premiums.** Rural Americans who have health insurance face higher premiums than other Americans because they usually have to purchase coverage alone or through a small business. They do not have the protection of being part of a large business or purchasing group that can successfully negotiate lower premiums.

- **Inadequate Coverage.** The insurance that rural Americans have often does not cover the health services they need, such as primary and preventive care. It often does not protect them from the catastrophic costs that may accompany a severe illness.

- **Lack of Choice.** Rural Americans have very little choice as to what type of health insurance to buy. Most rural Americans work for small businesses that offer no choice of coverage: Only 3 out of every 10 employers with fewer than 500 employees offer any choice of health plan.

- **Lack of Providers.** Physicians and other health care providers currently find few incentives to practice in rural areas. The fragile economies of rural communities and poor health insurance coverage provide little financial stability for rural health care practitioners and hospitals. Long hours and isolation wear rural providers out; the network of care-givers is stretched past the point of breaking. As a result, over 400,000 rural Americans live in counties without a single doctor and 34 million people live in rural areas with insufficient physicians to care for them.

- **Lack of Transportation Services.** Rural Americans have a harder time getting to the services that are available. Most rural communities lack any public transportation system. More than half of the rural poor do not own a car, and nearly 60% of the rural elderly are not licensed to drive.

Mr. Chairman, our nations's health care crisis will not go away by itself. The Health Security Act seeks to fix what's wrong with the health care system, while preserving what's right.

Now lets consider how to help solve these problems through the health care reform proposal President Clinton has proposed.

HOW THE HEALTH SECURITY ACT WORKS

Every American citizen and legal resident will receive a Health Security Card which guarantees private health insurance coverage that can never be taken away. The Act creates consumer-run insurance pools, called "health alliances," through which individuals and families will purchase their insurance coverage. Health alliances establish a marketplace for health insurance that is rational and consumer-friendly. Insurance plans will compete for business on the basis of cost, quality, and services. Further, because employees will choose their own health plans, their coverage will stay with them, even if they change employers.

It is through health alliances that the Health Security Act cracks down on unfair health insurance company practices. It will be illegal for insurance companies to deny coverage or charge higher rates because someone is older, has a history of medical problems, or is self-employed or a small business owner.

Employees and employers will share the cost of health insurance coverage under the Health Security Act. Most privately insured Americans now get their health insurance coverage through the work place, and the Act builds upon the strength of this part of the system. Employees who work for businesses with less than 5,000 employees will purchase their coverage through health alliances. Business with 5,000 or more employees will be allowed to self-insure as "corporate alliances," as will rural electric and telephone cooperatives.

The Act recognizes that not all families and small business will have the resources to purchase coverage – if they did, we would have universal coverage today. So, the Act provides premium discounts for low-income or unemployed families, as well as for small businesses employing low wage workers.

Everyone will have a choice of health plans and doctors. Families will be able to follow their doctors and nurses into a traditional fee-for-service plan, a network or preferred provider organization (PPO), or a health maintenance organization (HMO). The President's plan also preserves Medicare for the elderly, and even expands benefits by adding prescription drug coverage and a new community-based long term care program.

So, that's how the President's Health Security Act works. It guarantees private health insurance coverage for all Americans; makes insurance company abuses illegal; offers families a choice of plans and doctors; provides health benefits through the workplace; and preserves and expands Medicare.

AN UNPRECEDENTED FOCUS ON RURAL HEALTH CARE

The challenge of health care reform in rural America is to create a system that meets the unique needs and circumstances of rural communities. Health care reform must provide acceptable and appropriate programs for delivering and financing health care in rural areas, increasing the availability of care and opportunities for providers.

The Health Security Act targeted the needs of rural Americans from the earliest stages of its development.

- The special Working Group on Rural Health Care was formed to advise the White House Task Force on Health Care Reform.
- Rural health care experts from all over the country were deliberately brought to Washington to assist in the development of all aspects of the health care reform policy.
- Consultations with rural consumers, businesses, farmers, health care providers, and rural organizations occurred throughout the process.

The result is a health care reform plan with an unprecedented focus on rural health care based on the following principles: Security, Comprehensive Benefits, Savings, Quality, Choice, and Simplicity.

PRINCIPLES OF THE HEALTH SECURITY ACT WHAT IT MEANS FOR RURAL AMERICANS

Principle 1:
Security: Health Care That is Always There

The Health Security Act guarantees that rural Americans will always have insurance coverage, with comprehensive benefits -- no matter where they live or work.

Security comes in two forms: (1) affordable, secure insurance coverage, and (2) the availability of adequate health services. Here's how the plan guarantees security for rural Americans.

Affordable and Secure Coverage

- The Act provides coverage no matter where you work or if you work.

  The Act will guarantee coverage for those who lose jobs or switch jobs. Under the current system, if you lose your job you lose your health insurance. If you switch jobs, or start a small business, you are also likely to lose your health insurance.

- **The Act makes it illegal for insurance companies to deny or limit coverage because of "pre-existing conditions", sickness, or the kind of work you perform.**

  All health plans will be required to accept anyone who applies -- healthy or sick, young or old. It also prohibits insurance companies from dropping sick subscribers or selectively raising their premiums.

  Even during the three years before this plan is fully implemented, insurance companies will be prohibited from dropping subscribers or selectively raising premiums due to illness or accident. It also seeks to set up a government-sponsored insurance plan for consumers who cannot buy private coverage during the transition period.

- **It provides affordable insurance for those who farm or own or work in a small business.**

  Through the health alliances, all Americans will be able to get the lower prices now available only to large groups, giving rural Americans greater bargaining clout.

  Those who are self-employed in business or farming or are independent contractors, also will be able to deduct 100% of their health care costs from their taxes, compared to only 25% under the current system.

Assuring Adequate Services Are Available In Rural Areas

Here's how the Act helps assure that adequate services are available:

- **It holds states, alliances, and plans accountable for ensuring that rural residents have access to health services.**

  Alliances will be given the specific responsibility and authority to address the specific access problems of rural communities. They may assist in the development of health plans in underserved rural areas, and may also require health plans to serve rural areas within an alliance region.

- **It helps bring health care where its needed. The Act helps train, recruit and keep rural primary care practitioners:**

  - The Act changes federal funding of medical education to increase the number of family physicians and other primary care practitioners who are trained for rural practice.

    By 1998, 55% of all physicians in graduate training must be in primary care residency training programs. Currently only about 20% are entering primary care residency.

  - It promotes the full utilization of nurse practitioners, physicians assistants and clinical nurse midwives to help them better serve rural communities, and increases Federal funding to greatly increase the numbers of these mid-level providers who graduate each year.

  - The Act expands Federal National Health Service Corps loan repayment and scholarship programs to greatly increase the number of primary practitioners going to underserved areas.

  - It doubles the Medicare bonus payments for primary care services provided by physicians practicing in rural underserved areas.

  - It provides significant new tax incentives to attract providers to underserved areas. For example rural primary care physicians who begin to serve underserved areas may receive as much as $60,000 in tax credits over their first 5 years of service. Nurse practitioners may get up to $30,000 in tax credits over the same period.

  - The Act supports telecommunications linkages between rural practitioners and major hospitals and teaching centers to obtain expert advice, specialty consultation and professional continuing educations. These linkages reduce the isolation of rural providers and thus help to recruit and retain practitioners in rural areas.

Capacity Expansion and Enabling Services:

Capacity Expansion programs in rural and urban areas will provide:

- Grants for communities to form "community health plans and networks", enhancing their ability to compete in the new system and to maximize their control of their own destiny;

- Loans and loan guarantees to help capitalize programs serving low-income patients and underserved areas, including construction, renovations, and conversion of facilities to more appropriate uses; and

- Grants to public and non-profit entities to provide services that overcome non-financial barriers to care, such as transportation, outreach, and translation/interpretation services.

Principle 2:
Comprehensive Benefits: Keeping You Healthy

All Americans will receive a Health Security card that guarantees a benefit package that is as comprehensive as those offered by most Fortune 500 companies -- a package that exceeds the average coverage of most rural Americans. The comprehensive benefit package goes beyond most current rural Americans' insurance plans by covering a wide range of preventive services, including regular physical examinations, mammograms, Pap smears, and immunizations, at no charge. In addition, the package would provide for the following expanded services:

- Coverage of community-based long-term care services for elderly and disabled rural Americans. This is particularly important in rural areas where the percentage of elderly people is about 25% higher than for the nation as a whole.

- Essential support services for low-income rural populations to ensure that they have access to high quality care: transportation, translations services, and outreach, for example.

- School-based health care services in rural communities, where desired, to better enable our nation's young people to obtain essential preventive and other health services.

Principal 3:
Savings: Controlling Health Care Costs.

The Health Security Act cuts costs for rural Americans:

- The Act allows self-employed farmers and businesses to deduct 100 percent of their health care costs. Currently, the self-employed can deduct only 25 percent of these costs.

- It secures for farmers and small businesses the purchasing power of large groups to negotiate reduced insurance premiums.

- It eliminates excessive administrative costs associated with individual insurance policies for small businesses and farmers.

- It decreases excessive administrative costs for all doctors and hospitals by reducing the number of claims forms and reporting requirements. This will be a particular help to rural physicians and small rural hospitals for whom extensive paperwork consumes a higher proportion of their expenditures.

Principle 4:
Quality: Making the World's Best Care Better -- and Available Everywhere

The Health Security Act puts a new emphasis on preventing illness before it becomes a crisis. The Act provides a variety of incentives and programs to increase the supply of quality health services in rural communities.

- The Act promotes good health through expanded coverage of preventive and primary care services which all Americans need.

- It reduces professional isolation and the quality of medical consultation through the use of telecommunications technologies to link rural providers and major hospitals, allowing expert advice and information to be exchanged rapidly.

- It provides incentives for more family doctors to practice in rural communities, through enhanced reimbursement, tax incentives, and other financial incentives.

- It provides special training for providers to prepare for practice in rural areas.

- It requires states, alliances and plans to monitor their performance according to Federal standards to ensure that rural Americans have access to quality health care services.

Essential Community Providers:

- Many rural providers will be eligible for transitional protection as essential community providers, including rural health clinics, community and migrant health centers, and hospitals and doctors in underserved areas. This provision will assure that health plans contract with and pay essential providers for the service they provide under the benefit package. It will encourage providers currently located in rural areas to stay there.

Principle 5:
Choice: Preserving and Expanding Choices for All Americans

- **The Act expands choice by expanding the supply of health practitioners in rural communities.**

  Under the Health Security Act, a variety of programs are created to improve the training of practitioners for rural practice, and enhance the recruitment and retention of practitioners in rural communities.

- **The Act guarantees all Americans that they can continue to receive services from their physician in a traditional manner -- that is payment for each service, otherwise known as the "fee-for-service."**

  In some rural communities, there may be integrated health care plans; that is, plans in which people pay a fixed fee to receive all or most of their services from a group of providers. Under the Health Security Act, rural Americans will continue to have a fee-for-service plan available to them and the Act encourages development of more managed care options for rural areas.

- **It encourages the Development of Rural, Community-Based Health Networks or Providers and Integrated Plans.**

  Rural Health provider networks operated locally bring the benefits of greater cooperation and integration of services to rural communities. These integrated networks can provide good linkages to more specialized services. In many instances, these plans will contract with HMO's and insurance companies to manage the care of rural residents in their area that enroll the plans. In other instances, such networks may have the financial and population base to be able to become plans themselves.

  The Clinton Plan supports the development of locally sponsored rural health care networks and rural plans by removing legal barriers, providing market incentives and offering federal grants and loans to support and build networks and plans.

- **Encourages or Requires Urban Health Plans to Offer Coverage in Rural Areas.**

  Secure coverage and fair payment rates provide incentives for health plans to locate in rural areas for the first time. The health alliances can provide incentives or require health plans to expand to rural ares if it is in the best interest of rural residents.

Principle 6:
Simplicity

- **The Act reduces Paperwork and Cuts Red Tape**

  Rural physicians and other providers complain that insurance paperwork takes away from patient care. In rural areas, this paperwork is particularly burdensome since rural hospitals and physicians rarely have the resources to keep up. The plan will reduce the burden on physicians and hospitals for reporting and claims processing and will provide incentives for electronic data processing to reduce paperwork. It requires insurance companies to use a single form.

CONCLUSION

There is in my judgement a public consensus and a political consensus throughout this country on the need for health care reform. The Health Security Act is in one sense a conservative plan in that it attempts to preserve the American health care system we all are used to but to improve it as well. In another sense the President's plan is bold with the scope of benefits it proposes and the dream of universal coverage it realizes. The flexibility of the President has raised national hopes for passage of meaningful reform. We have done our best he seems to say and we can live with a changed plan if it encompasses comprehensive benefits and universal coverage. The plan he has introduced also takes important steps in reaching out to rural Americans with special provisions to bring to rural areas the health care that will make the reformed plan work for them as well.

Richland Memorial Hospital

Comments of Harvey Pettry

before the
House Subcommittee on
Rural Enterprises, Exports, and the Environment

Hearing on
Health Care Reform, Rural Small Businesses, and
the Rural Health Delivery System Development Act of 1994

June 23, 1994

Thank you, Mr. Chairman. I would like to express my appreciation to the members of the Committee for the opportunity to appear before you this afternoon. As the Chairman said, my name is Harvey Pettry and I have served as Administrator of Richland Memorial Hospital for ten years. I have served on the Illinois Hospital Association Board of Trustees for three and one-half years and have been Treasurer for the last 18 months. Richland Memorial Hospital is located in Olney, Illinois, a rural community of 9,000 people. Richland County has a population of 17,000 people.

Richland Memorial Hospital is a County-owned facility. Our Governing Board is the elected County Board.

- We run a daily hospital census of approximately 65 patients.
- We provide services to the residents of Richland County and the surrounding 7 counties.
  - About half of our patients come from Richland County and about half come from the surrounding counties in varying percentages.

Richland Memorial Hospital employs 450 full and part-time people. This is 5% of the County's total work force.

I would like to describe for you our role as a health provider in a rural community.

- We provide inpatient services including Med/Surg, Pediatrics, Obstetrics, Level II high risk nursery, psychiatric unit, skilled nursing and extended care/long term care beds.
- We provide typical inpatient and outpatient ancillary services including lab, x-ray, CT, mobile MRI, respiratory therapy, physical therapy, occupational therapy, speech therapy and nuclear medicine.

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-- We also provide somewhat nontraditional services in the form of the County ambulance service, home health program working in 5 counties and a hospice program.

I would like to call your attention to the significant economic impact of health providers in our community.

-- Richland Memorial Hospital has an annual payroll of $7.8 million.
-- We spend an additional $2.2 million locally for goods and services.

Most of our Medical Staff are members of the 21 member multi-specialty group practice, the Weber Medical Clinic, which was organized in 1896.

-- The Weber Medical Clinic employs 100 full and part-time employees and has an annual payroll of $5 million.
-- Therefore, in our small community, health care contributes almost $13 million in payroll alone into our community.

I would also like to call your attention to our contribution to the growth and development of our community beyond our role as health providers and employers.

-- We are directly or indirectly involved in the training and education of a large number of allied health staff.
-- The hospital is a site for the education of professionals in our area, including students in radiologic technology, medical laboratory, medical records, physical therapy, social workers, registered nurses and licensed practical nurses. This results in the increased availability of health manpower for our area.

We have employees serving on school boards in the area, we have employees serving on community boards such as I have served on in economic development, and we have employees serving on the boards of health related groups such as the Red Cross, Salvation Army and so forth.

-- Beyond that, Richland Memorial is also the sponsor of a variety of community and patient education programs.
    -- We provide support groups for patients with cancer, ostomies and diabetes and for the families of Alzheimer's patients.
    -- We provide parenting classes for pregnant women, especially inexperienced ones.
    -- We provide a monthly health forum with 60-100 attendees each month.
    -- We also provide assistance in upgrading neighboring ambulance services and we are assisting two counties in upgrading from the EMT-A to the EMT-I level.

These services that I have referred to are not "freebies" given away in competition with a neighboring hospital. They are community commitments on the part of our hospital and our employees and they affect the quality of life in our community.

I would like to make a few comments about the Rural Health Delivery Systems Development Act of 1994.

- I have had an opportunity to read an outline of the proposed legislation. I am truly excited by it and strongly support it.
- I think the section on encouragement to States in developing State Access Plans is very important.
  - Without the encouragement I am concerned as to whether States would truly make this step.
- I think the technical assistance for grants and assistance for development of networks is extremely important.
  - As the Administrator of a rural hospital, I have neither the staff, nor the time to develop the expertise for engaging in the development of networks. However, I recognize that networks are extremely important. I would welcome the opportunity to work with an expert on behalf of my hospital.
  - At this point the development of managed care in rural areas is too much related to one-to-one contracts between managed care companies and individual hospitals in order to get a discount, without the development of any true networks.
- I am also excited about the continued development of incentives for health professionals.
  - However, I hope there will be incentives to not only attract health professionals to the rural areas but that there will also be incentives to keep them beyond the two years.
  - I've seen too many National Health Service Corp and Rural Health Initiative physicians come to a rural area, spend the required two years, and depart for the cities.
- I think the provisions for innovative institutional programs, especially those relating to emergency medical services and telecommunications are very important.
  - The distances between hospitals will become greater as some small hospital facilities change to other purposes.
  - EMS services will be necessary to link those institutions.
  - Telecommunications will also be an important link in order to perform diagnostic tests in one area and transmit data and interpretations between institutions.

If I could, I would like to make several comments on health reform. My first comment relates to universal coverage.

- Five to six percent of the people in our area have no health insurance.
  - These are people too "rich" to be on Medicaid yet too poor to have any insurance.
  - Many of them are small business people, farmers, etc.
  - A number of them suffer from unnecessary illness and premature death.

- How can we accomplish health reform without covering them?
  - If we don't cover these people, then the individuals to benefit from health reform may be individuals such as myself, and I already have good insurance.

I hope that in health reform Medicare will become an integral part of the reform program.

- It is difficult for me to imagine how we would have health reform if we are not affecting 50% - 55% of our patient load.
- If we do not involve Medicare patients, then we will have 55% of our patients under the old Medicare program and 45% of our patients under a new health reform program.
- It will result in two different sets of incentives for our doctors and our employees to respond to and I think that will be an unworkable situation.

I would also like to express my deep concern about Medicare spending cuts.

- I understand that there is strong support for cutting Medicare as a way of paying for health reform.
- I believe the proposed cuts will prevent hospitals from taking care of their Medicare patients and their other patients.
  - Hospitals have had significant cuts in the last couple of years.
  - The cuts that are being discussed might not damage an urban hospital with a 30% Medicare patient load, but I have to tell you that our rural hospitals and communities will be damaged.
    - If we have to reduce expenses we will try to be more efficient, but ultimately result in limiting involvement in community activities and the elimination of patient education programs, patient support groups, young mother educational programs - many of those affected will be those most in need of services in our communities.

I very much appreciate the opportunity to appear before you this afternoon. I think that the Rural Health Delivery Systems Development Act of 1994 has great promise for the residents of rural areas. Furthermore, I believe that as Congressmen representing rural areas, you can impact health reform.

I hope that your Subcommittee will pursue these important legislative initiatives in order to continue viability of health services in rural areas and with additional benefit of maintaining the important contributions that rural hospitals make to their communities.

Thank you.

Statement by
Congressman Charles Stenholm

Hearing before the Subcommittee on Rural Enterprises,
Exports, and the Environment
Committee on Small Business

June 22, 1994

Mr. Chairman, I commend you for scheduling this hearing on "Health Care Reform, Rural Small Businesses, and the Rural Health Delivery System Development Act of 1994." I know that you have long been an advocate for rural areas when it comes to health care delivery. For the past four years you have been a valued member of the Rural Health Care Coalition's steering committee in your capacity as chairman of the Rural Mental Health Task Force.

As you know, on behalf of my co-chairman Pat Roberts, and other members of the House Rural Health Care Coalition, I have introduced The Rural Health Delivery System Development Act of 1994, H. R. 4555.

Now in the fourth year of my tenure as co-chairman of the House Coalition, I continue to feel that this organization has been one of the most effective and enjoyable institutional experiences of my congressional career. I have found that the non-partisan, "can-do" attitude of Members and staff of this Coalition have served it, and more importantly rural America, extremely well.

Recognizing that we are just one small piece of the larger health reform picture, we nonetheless have felt that during this period of reform it is absolutely critical that the concerns and needs of rural America be heard, respected and responded to. In constructing this bill, we in the Coalition sought to identify those consensus initiatives which did not presuppose any one approach to overall health

reform. Within the Coalition we have members who support medical savings accounts alone, single-payer advocates, those who support employer mandates and others who oppose them, managed competition believers and managed competition skeptics. What unites us, however, is our desire to promote rural health provisions, regardless of the system reform.

Having served as a member and subcommittee chairman here on the Small Business Committee, I know that most of this committee's members have a sensitivity to the role rural health plays in rural development and rural enterprises. We understand that if there are not health care providers in a rural area, there also will not be businesses which can sustain a thriving community.

Here in the Small Business Committee we also know that rural communities are not looking for hand-outs. They're not asking for the federal government to solve their problems. They don't want the federal government to parachute in with magic answers.

What rural Americans would appreciate is some help with the tools they need to deal with their local problems. They want to be able to create the systems that meet their local needs. This is true whether we are talking about health care, business development, education, or any other aspect of rural life.

During a conference entitled "Implementing Health Care Reform in Rural America," Dr. Bruce Amundson last year wrote "...the primary goal of reform must be to enhance the ability of rural communities to do what communities have historically done in America -- assume responsibility for the services and institutions that serve their residents. This argument simply recognizes the natural tendency in a democracy for populations to govern themselves, thereby mobilizing the immense energy, power,

and creativity of communities to address their needs." He continues to explain that what health reform should ensure for rural communities is community-owned and integrated delivery systems that organize the rest of the system from the bottom up.

That philosophy is precisely at the core of the bill we have introduce, H.R. 4555. Building on the foundation of programs which we know have worked in the past and incorporating some new ideas of what we believe will work in the future, we are seeking not to prescribe the magic answer for the thousands of rural communities across our country, but rather to enabling them to come up with their own answers. In taking this approach, we not only enable individual rural communities to take responsibility for their own answers; we also give them the tools to go beyond the piecemeal approach of some past rural programs, equipping them to respond comprehensively to their rural health needs.

We used two additional criteria in developing this bill. First, as I have already mentioned, we focused on consensus concepts agreed to in a bipartisan fashion. Secondly, we included only provisions structured uniquely for rural areas. We should mention that there are a number of excellent new proposals which aid rural areas as part of their effect, and individually many of us support those proposals. However, in compiling this bill under the auspices of the House Rural Health Care Coalition, we attempted to keep centered on rural beneficiaries.

In the Rural Health Delivery System Development Act, we give special attention to those chronically underserved rural areas which, in spite of existing federal and state programs, continue to lack access to affordable, high quality health care services. Even though the Health Personnel Shortage Area (HPSA) designation was designed to aid communities most in need, some areas consistently remain

unserved. Our goal is to catch those communities which previously have fallen through safety nets, encourage their own self-developed plans, and enable them to coordinate services to their residents. Through grants and technical assistance to those communities, they will be better equipped to develop the networks which will increase their access to health care.

In other efforts to respond to the need for additional health professionals in rural areas, we also amend the National Health Service Corps program, allow for student loan deferrals, Medicare bonus payments, and better utilization of non-physician providers. Also in this regard, we will fund demonstration projects to increase primary care physician residence training in rural areas. Through these measures we believe that we can increase the supply of health care professionals to rural areas.

We strengthen two other programs which have shown effectiveness in rural areas in the past: Community and Migrant Health Centers and Essential Access Community Hospitals (EACH/RPCH).

Finally, by amending hospital anti-trust laws, we hope to make it easier for rural hospitals to engage in the cooperation which everyone believes reduces duplication and waste, and assures better access to care.

The financing mechanism we have included in the bill is applying an affluence test to Medicare Part B premiums. Those individuals making over $100,000 or couples with incomes of more than $125,000 would be asked to pay a greater share of their monthly premiums for Part B Medicare. Although this provision would affect only two percent of the Medicare population, it would generate revenues of more than $4 billion over five years.

According to the best estimates we have, the bill's financing fully covers the costs of the programs. Given CBO's tremendous workload currently in scoring health legislation, we have not yet gotten a final CBO score. However, the primary sponsors of this bill are committed to fully financing this bill. Should later scoring show an unexpected short-fall, we will make adjustments in the bill as necessary.

With crystal-ball gazing having still not developed into an exact science, the authors of this bill make no presuppositions about what form health reform will take in the 103rd Congress. We believe that H.R. 4555 will fit into any larger health reform picture. The package has advocates on all of the major House committees dealing with health reform and our hope is to see these provisions moved forward out of those committees. If necessary, we also stand ready to offer any remaining provisions as an amendment on the House Floor.

As always it has been a pleasure to work with my colleague Pat Roberts on this bill. In addition, the co-chairs of the Health Reform Task Force, Representatives Gunderson and Slattery, have been most helpful, as have you, Mr. Chairman, as well as other Members of the Coalition's Task Force.

Let me mention finally that I commend you for the witnesses you have gathered today for this hearing. Dr. Habersang comes from a District which neighbors mine. I know he has an excellent understanding of the difficulties, and more importantly, the successes that are possible in rural areas. I believe he will mention in particular two provisions, the Border Health Commission and the revising of the formula for reimbursing rural physicians, which are of particular interest to Texans.

I also am pleased to see my friend Jeff Human, who has led the Office of

Rural Health Policy since we first created it at the beginning of the Coalition's efforts. And finally, I want to mention that Chuck Fluharty, who represents the Rural Policy Research Institute, provided extremely valuable input as we were developing H.R. 4555.

Again Mr. Chairman, thank you for conducting this hearing. I look forward to working with all of my colleagues in seeing these provisions enacted into law.

TESTIMONY SUBMITTED BY MICHAEL E. BRUNNER
EXECUTIVE VICE PRESIDENT
NATIONAL TELEPHONE COOPERATIVE ASSOCIATION
REGARDING RURAL HEALTH CARE CONCERNS
DEVELOPMENT OF RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT
SUBCOMMITTEE
U.S. HOUSE SMALL BUSINESS COMMITTEE
JUNE 23, 1994

The health reform debate has brought noteworthy attention to the health care dilemmas that rural Americans confront daily. The challenge of universal affordable coverage for everyone is a difficult task and one compounded when "everyone" includes a low density population which faces limitations on the ability to attract and keep quality doctors, and which encounters time and distance worries every time it attempts to obtain advanced medical treatment. A general lack of economic resources in rural communities is above all else, the greatest obstacle.

The National Telephone Cooperative Association (NTCA) acknowledges the work of the Administration, congressional leaders, and members of the Rural Health Care Coalition for bringing this issue to the forefront and developing a means to address rural health challenges. NTCA should also be recognized for the experience and expertise it has gained over the years as a provider and innovator of health plan and technological systems designed to facilitate rural health care delivery.

Representing nearly 500 rural cooperative and commercial telephone systems in 45 states, NTCA has been an active leader within the telecommunications industry in developing solutions to the unique and growing health care needs of rural America. NTCA members understand the health access issues facing the communities they serve and have taken steps to respond to a situation we all agree has reached crisis proportions. First, NTCA has a twenty year history of assisting its telephone industry members in providing health benefits to their employees and dependents. Currently some 30,000 rural Americans benefit from NTCA's Group Health Program (GHP). Moreover, the GHP has adopted a variety of managed care arrangements to assist in containing health care costs. Accordingly, NTCA has specific concerns with health care reform proposals which are counterproductive to the initiatives that NTCA member systems have taken to keep their employees, and their communities, well and working.

NTCA member telephone systems, like most of the country's independent local exchange carriers, evolved during the early part of this century to serve low density, high cost areas of this country. In fact, while rural telephone subscribers consist of a mere 4.3 percent of the nation's total number of telephone customers, the areas served by independent telcos (NTCA members) account for 40 percent of the nation's geographic area. But NTCA's members also understand that in order for their operations to remain viable, the community which they serve must remain adequately developed economically.

As such, NTCA members have been obliged to seek out ventures to establish the strength and vitality of their communities. Job creation, job retention and essentially the actual existence of a community, would be threatened if infrastructure growth is not properly reinforced, and access to health care services is a key component.

NTCA supports assistance for the establishment of community rural health networks in chronically undeserved areas, incentives for health care providers to serve and remain in these areas, and envisions advanced telecommunications infrastructure as a step in the right direction to sustaining these goals.

Telecommunication applications for rural health care

Over the past several years rural telcos, hospitals, clinics and health centers have been responding to the rural health care access void through telecommunications health links. Understanding that communities will flounder without adequate health care access, these links are helping rural communities overcome isolation, and the battle to recruit and retain trained health care professionals. Also, over time, tele-health links can be utilized to enhance the level of services available to rural residents, and to provide continuing medical education to rural health providers. The transmission of voice, video, and data, along fiber telephone lines, microwave and satellite systems has unlimited potential for all that health reform advocates are proposing.

While it is encouraging to see the attention given this matter, the deterrent for the development and implementation of these technologies of course is a factor of cost. There is the cost associated with the installation of transmission facilities and equipment, the portion the tele-health link the telecommunications provider is responsible for, and the cost of the end-user equipment, such as video monitors, and use of transmission facilities.

Rural telcos are fortunate to have the Rural Electrification Administration's (REA) telephone loan program in place to assist in the financing the capital investment necessary to develop a modern network and provide the transmission capabilities. Congress recognized the future telecommunications needs of rural America when creating the program in 1949, and making the program responsible for extending low interest loans to both "...furnish and improve..." rural telephone service.

And in 1990, Congress established REA's Distance Learning and Medical Link Grant Program to respond to the financing needs of tele-health link end users. This grant money is available for schools, hospitals, and clinics to finance the equipment necessary to bring the services to their facilities. Unfortunately for FY91-FY95 only **$20 million** has been appropriated for a program authorized at **$245 million** for that four year period. In response to the Administration's request that an additional **$5 million** be appropriated for FY95, the House just last week approved a mere **$7 million of $60 million** authorized. In light of the fact that the Administration has endorsed health care reform as the centerpiece of its agenda and more than two hundred rural medical and educational

applicants have already requested consideration for these tele-health link funds, it is discouraging to see such inconsistencies in the Administration's priorities.

NTCA fears that the assistance provided by the proposed Community Rural Health Network Development Grant program for health networks which could include telecommunications information systems, would simply be yet another underfunded government project. The Rural Health Care Coalition has submitted noble solutions to rural health problems in H.R. 4555. But the solution to a good portion of rural America's health deficiencies, is inherent in the incentives and solid experience of a program that exists today, the REA Distance Learning and Medical Link Grant program. There is an experienced technical staff in place with a proven track record in working with rural community health organizations. We strongly recommend that Congress reiterate its support for this successful, but underfunded program by appropriating funds consistent with the level authorized by Congress when this program was established. NTCA member systems bear a proud record of leadership, by utilizing REA's financing and development assistance, in responding and meeting the health care needs of rural America.

Geisinger

GEISINGER HEALTH SYSTEM
DANVILLE, PENNSYLVANIA

TESTIMONY FOR THE
RURAL ENTERPRISES, EXPORTS AND THE ENVIRONMENT SUBCOMMITTEE
OF THE HOUSE SMALL BUSINESS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

JUNE 23, 1994

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to present written testimony on behalf of the Geisinger Health System regarding our efforts to develop and implement a model telemedicine/telecommunications network that will enhance the delivery of cost-effective, integrated health care services in rural, underserved areas.

The Geisinger Medical Center, founded in 1915, is a 577-bed facility in Danville, Pennsylvania that has become the hub of the nation's largest rural health care system. Today, the Geisinger system is a multi-institutional network serving 31 rural counties and 2.3 million people in central, northcentral and northeastern Pennsylvania. In addition to Geisinger Medical Center, which serves as the region's tertiary referral and Level 1 Trauma Center, the system includes a 230-bed regional hospital and cancer center in Wilkes-Barre, and 45 physician practice clinics in 38 communities in rural and isolated areas. Geisinger also has the largest rural HMO in the country, the profitable 161,000 member Geisinger Health Plan.

As one of the dozen major clinics in the country and one of only four rural referral tertiary care centers of 500 or more beds, the Geisinger system embodies many of those major characteristics sought by Congress and the Clinton Administration on health care reform. Geisinger has been continually cited as a prototype for health care reform, including the following national endorsements:

- First Lady Hillary Rodham Clinton, Pennsylvania Senators Wofford and Specter, Congressman Paul Kanjorski and other legislators have endorsed Geisinger's group practice/managed care concepts as a national model for health care reform.

- The New York Times featured Geisinger's network of 530 salaried physicians as an innovative and cost-effective managed health care system.

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- Arnold Relman, M.D., former editor of The New England Journal of Medicine, refers to the Geisinger system with its HMO as the harbinger of what is going to happen in health care all over the country.

- The National Committee for Quality Health Care offers the Geisinger approach as one of several national models for reforming American health care.

Central to our development of a telemedicine/telecommunications network is our commitment to providing quality health care services for the rural communities which comprise our managed care system. Indeed, health care, particularly in rural areas, is an indicator not only of economic development but of quality of life. We at Geisinger are committed to providing our rural communities with better access to medical care and patient information that will lead to economic growth in our region.

In the past eighteen months Geisinger has begun to implement services requiring higher network speeds and has been confronted with the issues of delivering these services over a wide area network in rural Pennsylvania. Primary among barriers in delivering quality services in rural and isolated areas is the inability to efficiently transmit medical information between health care providers, particularly among rural practitioners and referral centers. This obstacle impedes the delivery of coordinated care and adds significantly to costs to patients. We believe that a telemedicine/telecommunications system can address the barriers that, directly and indirectly, reduce efficiency in the delivery of health care, particularly in underserved rural settings.

The Geisinger system represents an ideal setting for testing strategies that would use information technologies to foster cost-effective, high quality integration of health care services among providers in a large rural area. Geisinger is already experienced in developing collaborative relationships both within its own diverse and widely dispersed network as well as with non-Geisinger providers in the service region. Successful outcomes will be a valuable resource to other providers throughout the country. The demonstrated cost savings achieved through increased efficiency directly address a top priority of health care reform. Therefore, we plan to develop and implement a multifaceted communications network that could serve as a national model for rural health care providers.

As envisioned, Geisinger's telecommunications/telemedicine network will have several areas of emphasis:

- Reducing the isolation of physicians and patients in rural areas and expanding opportunities for local communities to have interactive communication capabilities that can be used for numerous activities including ongoing education and training programs for physicians and other providers. Our network will provide for the economically efficient interaction of physicians and administrators at different locations without disruption to patient care.

- Improving and stabilizing the impact of health care reform on the medical work-force in small, rural and underdeveloped communities by upgrading and converting existing medical facilities to ensure their continued and efficient operation without significant job losses. Without telecommunications and telemedicine capabilities, small, isolated communities will be unable to adapt to changes pushed through in health care reform.

- Exploring new models for delivering care in rural, underdeveloped areas by demonstrating how the existence of this information infrastructure can lead to fundamental, cost-efficient changes in the practice of medicine, changes that would not be available without the tools provided by high speed telecommunications. This will include:

  -- Permitting consultations between specialists and primary care providers at distant or remote locations;

  -- Permitting radiologists to serve many geographically remote sites through electronic imaging technologies, particularly service areas that cannot financially sustain independent radiologic services; and

  -- Developing the elements of an electronic medical record (physical history, laboratory and pharmacy data).

Through this network, we intend to show that a highly functional, cost-efficient telecommunications system using available technology can make a major contribution to the development and standards of living in rural communities, namely, better patient access and higher quality health care at lower cost. Additionally, an interactive telecommunications network will allow Geisinger to recruit and retain primary care physicians into small communities that would otherwise be without medical services.

The timing for our proposed medical telecommunications project parallels the priorities outlined by the Congress, the Administration and the State of Pennsylvania. The government's leadership in health care reform and telecommunications exemplifies the Geisinger telemedicine network as a model approach to utilizing state-of-the art technologies in providing quality, affordable health care services.

Geisinger Health System proposes three initial projects to demonstrate the effectiveness of our telecommunications/telemedicine network:

1. Videoconferencing and nutrition education for health professionals, students and elderly persons;

2. Emergency room videoconferencing; and

3. Teleradiology

Geisinger Health System is prepared to demonstrate that advanced telecommunications technologies can improve the quality of life and accessibility of health care in rural and medically underserved areas and reduce the costs of such care. Our network will be multifaceted to support a variety of health care activities -- including the development of computerized medical records, education and training for primary care providers, teleradiology applications, improved emergency room services, and other interactive communication uses to link isolated physician sites with the main Medical Center.

Geisinger's network will enable physicians and clinics in isolated and remote areas to provide cost-effective, integrated health care services to their communities. Furthermore, this network will be designed to accommodate the unique needs of an HMO in a rural area. Geisinger Health System already embodies many of the concepts sought by Congress and the Administration for health care reform. This experience makes us uniquely qualified to develop a telemedicine/telecommunications network that could become a prototype for other health care providers in underserved areas.

Thank you for the opportunity to testify on behalf of Geisinger Health System.

TESTIMONY BY THE HONORABLE PAT ROBERTS (R-KS)
HEARING BEFORE THE SMALL BUSINESS SUBCOMMITTEE ON RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT

JUNE 23, 1994
2:00 P.M.
2359 RAYBURN BUILDING

Mr. Chairman, thank you for the opportunity to discuss rural health care legislation with you today. I am pleased to be able to sit in this capacity with Mr. Stenholm and represent the 151 members of the House Rural Health Care Coalition.

It is obvious we need to improve our health care delivery system. Many farm and rural associations have known this for years. Rural communities have been forced to develop solutions to their unique problems. However, they need the proper tools. I don't believe vast sums of money or regulatory schemes are the tools they are looking for. I do believe in ensuring that the limited federal health care pie is sliced fairly, and that rural priorities are given fair consideration.

Compromise is a way of life for rural Americans. Rural residents have fewer choices of physicians or hospitals. There is generally little choice if the patient wishes to be treated near home. Rural physicians must settle for fewer medical colleagues to rely on for consultation and support. Rural facilities utilize less-sophisticated hospital equipment.

It is obvious that the rural health care delivery system deserves special attention. The important components of a rural health system must be clearly defined and understood by every member of this Congress. Giving rural communities the tools they need must be the cornerstone of any bill that is passed. For this reason, Mr Stenholm and I have introduced a package of sensible rural health provisions that must be included in health care reform. The "Rural Health Delivery System Development Act of 1994" includes provisions that the Coalition has previously endorsed, as well as additional programs to encourage voluntary network development in rural and underserved areas.

Today, I would specifically like to point out some of the incentives and assistance we have included for rural health providers and facilities.

National Health Service Corps Program

The shortage of health care professionals in rural areas continues to be the main barrier to the access of health care services in rural areas. For example,

while the United States averages 2.4 physicians per 1000 residents, eighty-two of Kansas' 105 counties have less than 1.0 physicians per 1000 residents.

Many programs aimed at improving access to health care and attracting physicians to rural areas are tied to the National Health Service Corps. In determining assignments for National Health Service Corps personnel, areas that have been designated as Health Professional Shortage Areas (HPSAs) are given priority. In many areas, this designation is the most important criteria for determining whether rural physicians are eligible for additional incentives in rural areas.

Unfortunately, recent studies have indicated that the HPSA designation is deficient in its ability to adequately define underserved populations. This legislation would:

- Amend the HPSA definition to take into account the high concentrations of Medicare, Medicaid and uninsured patients found in rural areas as additional criteria to indicate underserved populations.
- Extend bonus payments for three years to physicians in rural health shortage areas that lose their designation.
- Increase funding for the National Health Service Corps.

Primary Care Incentives

The nation's supply of doctors grew nearly 3.5 times as fast as the general population during the past decade. Yet the percentage of physicians trained in primary care has been falling steadily, reaching as low as 32 percent in the last few years. This shortage of primary care doctors constitutes one more barrier to access to health care in rural areas. This legislation includes the following additional incentives to encourage physicians and other health care professionals to enter primary care:

- Defer student loans for interns and resident doctors in primary care training programs.
- Adjust the geographical indices to correct for lower reimbursement of rural physicians' services.
- Expand the training of mental health professionals and nurses in rural areas.
- Redirect Medicare-supported Graduate Medical Education (GME) funds to support state demonstration projects to encourage primary care and rural-based educational experiences.

Assistance for Rural Health Facilities

Hospitals and health clinics face special problems in meeting the needs of rural areas. This legislation would assist rural facilities by:

- Expanding options for hospitals to provide emergency care in rural areas
- Establishing a Federal Office of Emergency Medical Services to develop regional emergency care networks.
- Enhancing systems for the air transport of rural victims of medical emergencies.
- Adding flexibility to the current Essential Access Community Hospital (EACH/RPCH) regulations
- Increasing funding for Community and Migrant Health Center programs.

Telemedicine

Telemedicine is particularly important to rural health delivery systems. It assures less professional isolation for rural physicians, a critical component needed to recruit more health providers to rural areas. This bill expands telecommunications options for rural medical facilities, allowing them to establish links with larger, more technologically advanced facilities.

Mr. Chairman, not all rural areas area alike. Rural Kansas is different from rural New York and each community must have the flexibility to structure health delivery systems that take into account special circumstances. This legislation will help to ensure that all rural areas are given the opportunity to expand services and develop networks utilizing the facilities and providers that exist in each particular community.

This legislation is not intended to restructure the current health care delivery system or create new bureaucracies. It is crafted to support ongoing efforts, including establishing tax fairness for all the self-employed, to make health care more accessible and affordable for rural areas. Congress cannot afford to pass a national health care reform plan that does not take into account the special needs of the rural health delivery system. Rural folks deserve access to the same quality health care as those living in urban areas.

Again, thanks for letting me share this information with the Committee. I appreciate your interest in rural health and look forward to working with you to improve our nation's health care system.

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